

University of Maryland Center on Aging

*Medicare/Medicaid
Integration Project*

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**Integration of Acute and Long-Term Care
for Dually Eligible Beneficiaries
through Managed Care**

A Technical Assistance Paper of the
Robert Wood Johnson Foundation
Medicare/Medicaid Integration Program
an initiative directed by the
University of Maryland Center on Aging

Prepared by

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and
The National Academy for State Health Policy

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The Medicare/Medicaid Integration Program

The purpose of the Robert Wood Johnson Foundation Medicare/Medicaid Integration Program, (MMIP) is to end the fragmentation of financing, case management, and service delivery that currently exists between Medicare and Medicaid. States will be provided with grant support and technical assistance in their efforts to restructure the way in which they finance and deliver acute and long-term care. Technical assistance will focus on those states that have been awarded grants, but not be limited to grantees. It is recognized that other states and initiatives can benefit from this help. This paper represents one such effort.

The Foundation staff responsible for the program are: Nancy Barrand, Senior Program Officer; James Knickman, PhD, Vice President For Research and Evaluation; and, Diane Montagne, Program Assistant. The National Program Office (NPO) for the program is based at the University of Maryland Center on Aging under the direction of Mark R. Meiners, Ph.D. The NPO will provide technical assistance and direction for the initiative. Hunter McKay is the Deputy Director for the program.

The MMIP Application Kit contains a complete set of budget and narrative guidelines. Requests for application materials and information about the MMIP can be obtained from the following locations:

Web Site: <http://www.inform.umd.edu/aging>

Phone/Fax: 301-405-2471 (phone) -- 301-314-2025 (fax)

ALERT TO READERS!!!

Congress was poised to pass the Balanced Budget Act of 1997 as this paper went to press. The Act makes significant changes in the managed care options under Medicare and Medicaid. The specific impact on state dual eligibility initiatives must await the drafting of regulations by HCFA. The major components of the Act include:

Medicare

- ✎ Medicare beneficiary options are expanded beyond fee for service and Medicare HMOs to include preferred provider organizations (PPOs), provider sponsored organizations (PSOs) and, for a limited number of beneficiaries, medical savings accounts (MSAs).
- ✎ Beginning in January 2002, an annual open enrollment period will be held during which Medicare beneficiaries will make their Medicare choices. Beneficiaries will be able to change their selection once during the open enrollment period but must otherwise remain in the plan of their choice for the remainder of the year.
- ✎ Changes in the adjusted average per capita cost (AAPCC) payment methodology will, over time, bring high and low payment areas closer together, making Medicare risk contracting more attractive to MCOs in rural and other low payment areas.
- ✎ The Medicare HMO 50/50 composition rule is replaced by enhanced quality standards.

Medicaid

- ✎ States have the option to implement mandatory risk-based managed care and primary care case management programs without waivers, through amendments to their state plans. However, states can not use the state plan option to require dually eligible beneficiaries to enroll in Medicaid managed care.
- ✎ States may continue to seek waivers under sections 1915 or 1115 to implement programs that exceed the authorization contained in the new state plan option.
- ✎ Beneficiaries enrolled in managed care plans may change plans once during the first 90 days of enrollment and at least every 12 months thereafter.

These changes broaden the managed care options under Medicare which should make it easier for states to contract with MCOs eligible for Medicare contracts. The Medicare open enrollment period and the requirement that beneficiaries must remain in the plan for a calendar year is consistent with the 12 month "lock-in" provision under Medicaid.

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Executive Summary

Managed Care as Vehicle for Integration

This paper discusses technical aspects of acute and long term care integration for dually eligible beneficiaries through managed care. It is intended primarily to assist states considering managed care approaches for dually eligible beneficiaries. While other options are of interest to states and HCFA for this population, including fee-for-service based case management systems, managed care/fee-for-service hybrids, and consumer directed systems, the purpose of this paper is not to provide comparative analysis of multiple approaches to serving dually eligible beneficiaries. Rather, the focus is on the use of managed care for the population, and the multiple forms managed care can assume.

What is Integration?

Though many state and federal policy makers and program designers are intrigued by the notion of integration, we are still without a broadly accepted definition. This paper joins the struggle for definition by breaking integration into component parts, including integrated benefit packages, delivery systems, quality mechanisms and financing, and discussing the technical challenges of integration within each component.

From a dually eligible beneficiary's point of view, integration of acute and long term care means that multiple systems feel and act as one. The integrated system is easy to use and provides appropriate care when it is needed, regardless of the type of care required. Thus, the beneficiary has easy access to primary, acute and long term care through a single, accountable point.

Integration v. Coordination

Full integration requires integration of many program components. Whether a state can or wishes to meet all the conditions of full integration at the outset of its program will depend on the state's infrastructure, market conditions, political considerations and implementation schedule.

As a trail blazer in this area, the Minnesota Senior Health Options (MSHO) program has received well-deserved attention, but states should not automatically move to replicate MSHO without careful consideration of that State's somewhat unique circumstances. Before launching MSHO, Minnesota had considerable experience enrolling elderly people in risk-based managed care, and initially, MSHO is being implemented in an urban market with one of the highest managed care penetration rates in the country.

Some states may choose approaches that begin with program coordination or partial integration as a reasonable stepping stone to a fully integrated model. The danger of an incremental approach is that it may lose its focus and momentum over time, but if a state has established clear goals, they can serve as the touchstone for each successive step in program development.

Integration Building Blocks

When a state is designing an integrated program, integration may be broken into its component parts. Whether a state attempts them all at once or in increments, the following components may be viewed as building blocks toward integration:

- *Broad and Flexible Benefits.* In order to integrate care, a program should be able to offer a broad range of benefits, including primary, acute and long term care. The benefit package should be flexible and responsive to individual needs and not simply replicate fee-for-service Medicaid and Medicare benefits;
- *Far-Reaching Delivery Systems.* If a program is to include a broad range of acute and long term care services, the delivery system should have capacity and experience beyond what is offered by traditional Medicaid or Medicare HMOs. Community-based long term care, case management and a host of specialty providers should be included in the delivery system through capacity building or strategic partnerships;
- *Care Integration.* The program design should include mechanisms for actual integration of care at the beneficiary level, such as case management, interdisciplinary care teams and centralized member records. Otherwise, a program may do little more than recreate a fragmented array of services under an ineffective program umbrella;
- *Unified Program Administration.* Medicare and Medicaid enrollment, disenrollment, data collection, payment and other systems should be unified, at least through the eyes of the beneficiary. The beneficiary should be interacting with one system regarding all Medicaid and Medicare administrative issues;
- *Overarching Quality Systems.* A single point of accountability should be established, Medicare and Medicaid quality requirements should be unified, and a quality umbrella should be established that moves beyond the traditional quality systems based on individual provider performance; and
- *Integrated Financing.* Medicare and Medicaid funding should be flexible, and the incentives created by the two major payors should be aligned to eliminate cost shifting.

A Few Givens

States should be creative in designing new approaches to integration that will achieve their goals and fit their particular landscapes. However, indications are that the following conditions will be necessary to win HCFA's support:

- *Medicare Freedom of Choice.* Programs must ensure that a dually eligible beneficiary is able to exercise his or her statutory right to choose Medicare providers. HCFA's position on this stems from §1802 of the Social Security Act, which *may not be waived*:

Any individual entitled to insurance benefits under this title [XVIII] may obtain health services from any institution, agency or person qualified to participate under this title if such institution, agency or person undertakes to provide him such services;

- *Medicare Cost Sharing.* States must meet their obligation to pay Medicare cost sharing for dually eligible beneficiaries, regardless of where the beneficiary receives Medicare services. HCFA will not approve arrangements (as it has in the past), in which cost sharing is only available through designated managed care plans;
- *Lock-in to Plan.* Once a dually eligible beneficiary chooses a managed care plan, the beneficiary must be able to leave that plan for Medicare benefits on a month-to-month basis. While states may fashion longer lock-in periods for Medicaid, this is currently the longest permissible lock-in for Medicare. However, this is an area likely to change in the future. As of this writing, Medicare provisions in the federal Balanced Budget Act of 1997 included movement toward an annual open enrollment period for Medicare, beginning in 2002; and
- *Cost Neutrality.* Programs must be cost neutral. If both Medicaid and Medicare waivers are requested, the program must be cost neutral to *each* funding source *independently*. It is not sufficient to show overall cost neutrality for the two programs combined.

Managed Care Vehicles for Integration

Several vehicles have emerged around the country as suitable for integrating Medicare and Medicaid services. The one or more vehicles selected by a state will depend on program goals, purchasing philosophy and availability. Vehicles include:

- Medicare managed care contractors, which are currently limited almost exclusively to HMOs, but which will be expanded to include provider-sponsored organizations (PSOs), preferred provider organizations (PPOs) and other forms of managed care under the federal Balanced Budget Act of 1997;

- National demonstration programs, including Medicare Choices, Social HMO II, PACE and EverCare. (PACE becomes a permanent option under the federal Balanced Budget Act of 1997); and
- Medicaid MCOs, including traditional Medicaid HMOs and community-based organizations that are willing and qualified to bear risk.

None of these vehicles will universally meet the needs of all states, nor is it necessary for a state to settle on a single approach. A state may want to use a combination of vehicles to reach distinct populations, cover certain geographic areas, or simply take full advantage of the existing market place.

Waiver Options

The waivers a state needs will depend on the program features and vehicle selected. There is no single combination of waivers required, and states have been creative with assistance from HCFA. Waiver requirements have been thrown into a state of flux by the Balanced Budget Act of 1997, but as of July, 1997, the following guidelines applied:

- *Medicaid Freedom of Choice.* As previously stated, *Medicare* participation must be voluntary, but a number of states have fashioned programs with *mandatory Medicaid* components. Currently, in order to do so, a state must have a §1915(b) or §1115 waiver. Although Medicaid waivers will not be required in as many situations under the Balanced Budget Act of 1997, it appears that most programs targeting dually eligible beneficiaries will still require Medicaid waivers;
- *Changes in Medicaid Services.* If the program will offer Medicaid benefits outside traditional Medicaid services, a state must have a §1115 waiver, unless the changes in services are limited to home- and community-based long term care, in which case a §1915(c) may suffice;
- *Changes in Composition.* If the desired contractor does not meet Medicaid's 75/25 membership composition rule, or Medicare's 50/50 rule, waivers are needed to engage in full risk contracting. Waiver of Medicaid composition requires a §1115 waiver; Medicare composition may be waived through §222. The federal Balanced Budget Act of 1997 will eventually replace the Medicare composition rule with enhanced quality and outcome measures; and
- *Medicare Payment Variations.* If a state chooses qualified Medicare risk contractors and is willing to accept the existing AAPCC payment methodology for Medicare, no Medicare waiver is needed. However, if a state desires capitated Medicare payments to MCOs that are not Medicare risk contractors, or if any alteration to the AAPCC is desired (whether or not the contractor is a Medicare risk contractor), a Medicare §222 waiver is required.

The Next Generation

The Health Care Financing Administration and The Robert Wood Johnson Foundation are both sponsoring demonstration programs that focus on dually eligible beneficiaries, and are challenging states to think about the next generation. At this writing, bipartisan agreement had just been reached on the Balanced Budget Act of 1997, expanding Medicare managed care to include several new entities and products, and eliminating the need for waivers in certain Medicaid managed care programs.

This paper dissects integration of acute and long term care into component parts, encouraging states to think of integration not in terms of models, but as a set of building blocks that may be assembled in many different combinations.

A. Introduction

Background

As states have gained experience enrolling mothers and children in Medicaid managed care, they have become increasingly interested in expanding managed care to other Medicaid populations. Indeed, the period 1994-1996 witnessed a 67% increase in the number of state Medicaid programs enrolling aged, blind, and disabled beneficiaries. Unlike the population of mothers and children with whom states built their early managed care programs, however, these new populations require a broader array of services and rely not just on Medicaid but also on Medicare for substantial health care financing. Where Medicaid is the primary payer of most care provided to mothers and children, most aged, blind, and disabled beneficiaries receive from Medicaid long term care services and limited primary and acute care not otherwise covered by Medicare. Some persons with disabilities are not eligible for Medicare, but the majority of the aged, blind, and disabled now enrolling in Medicaid managed care are also eligible for Medicare. Thus states have a growing interest in initiatives to integrate acute and long term care and the two payment sources - Medicaid and Medicare - which cover these services. Because states share responsibility for dually eligible beneficiaries with the federal government, these initiatives require strong collaboration between states and HCFA.

Defining Goals: What Does a State Wish to Achieve By Integrating Acute and Long Term Care?

Three factors have influenced the movement of states to integrate acute and long term care:

- The desire to improve continuity of care across settings and to provide flexible benefits that prevent or reduce institutionalization;
- The need to control costs; and
- An interest in expanding managed care to all Medicaid beneficiaries and minimizing the administrative complexities of operating both fee for service and risk based systems.

Continuity of Care and Benefit Redesign

The National Long Term Care Channeling Demonstration of the 1970s and the growth of Home and Community Based Waivers of the 1980s, brought states the opportunity to coordinate acute and long term care for frail elderly and certain persons with disabilities through case management. Both programs were targeted at those who were likely to require institutional care and sought to arrange alternative home and community services. While states experienced considerable success in developing home care alternatives, both programs still had limits on the type, duration, and scope of services provided and neither addressed the needs to prevent illness and disability. That is, beneficiaries presented at home care programs with levels of illness and disability that begged the question of

whether sufficient primary and preventive care had been delivered under Medicare. Nor did case managers have the capacity or authority to truly integrate care. For example, a beneficiary of Medicaid waiver services could experience an episode of acute illness, requiring hospitalization. The Medicaid case manager would likely lose contact with the beneficiary once hospitalized under the Medicare program. At hospital discharge, the beneficiary may be placed in Medicare reimbursed home health or a skilled nursing facility, unknown to the Medicaid case manager. Such disruption in service, despite case management, is not uncommon in waiver programs. While case managers can have considerable impact on coordinating care, they lack authority over the entire Medicaid and Medicare scope of services. Waiver programs often expanded the types of services reimbursable but did not provide opportunity for significant benefit redesign nor were programs able to access or re-direct Medicare expenditures. Additionally, the Medicare program provides benefits designed to better manage the needs of those with chronic illness. Some of these benefits duplicate Medicaid benefits; often they are required to be provided by skilled medical personnel when case managers may believe less medical intervention is appropriate. These home care initiatives, then, led states to recognize the need to coordinate acute and long term care and identified the need to build more preventive care into the Medicare primary and acute care benefit to possibly forestall and better manage the impact of chronic illness and disability.

Control Costs

Waiver programs also created the opportunity and often the incentive to cost shift between programs. A Medicaid case manager can refer a beneficiary to Medicare reimbursed services prior to paying for those services under Medicaid. A Medicare home health provider can exhaust skilled nursing benefits then transfer the beneficiary for Medicaid reimbursement. Strong incentives to maximize reimbursement can displace beneficiary centered care planning, which integrates acute and long term care services.

State incentives to maximize Medicare reimbursement and reduce cost growth are strong as well. Since aged, blind, and disabled beneficiaries comprise only 27% of Medicaid enrollees but expend 59% of its resources, states grew intrigued with the question: Can Medicaid managed care for dually eligible beneficiaries make these costs more predictable and reduce cost growth, as had been their experience enrolling mothers and children? Most of Medicaid's expenditure growth for elderly and disabled populations has been in institutional services. Despite significant efforts to reduce reliance on nursing homes through home and community based waivers, states still struggled with what they perceived as a persistent and resilient institutional bias in the Medicaid program. The attraction of capitating a health plan for acute and long term care services promised an approach which might prove successful in reducing the costly reliance on nursing homes and provide beneficiaries with greater choice of service and residential options.

Finally, states were motivated to address the cost concerns of a non-integrated acute and long term care system with passage of the Medicare Catastrophic Coverage Act of 1988. That law required state Medicaid programs to pay Medicare cost-sharing for certain low income beneficiaries who did not otherwise meet Medicaid eligibility requirements. For

this new group, states became responsible for meeting Medicare cost sharing without any capacity to control what and how many services were provided.

Expand Managed Care to All Populations

Historically, most states excluded aged, blind, and disabled beneficiaries from Medicaid managed care, but as states gained managed care experience, interest has grown in developing managed care for all populations under Medicaid. While other vehicles exist to coordinate Medicare and Medicaid, states have become convinced that managed care is a useful vehicle to deliver cost effective, quality health care. But they have also been frustrated by the complexity of maintaining both fee-for-service and managed care programs. By enrolling all populations in managed care, states hope to streamline data, billing, reporting, quality and other administrative systems and no longer run a separate fee-for-service program. In certain states, the move to Medicaid managed care for dually eligible beneficiaries has also been stimulated by growth in enrollment in Medicare HMOs. While Medicare HMOs are still not available in all parts of all states, enrollment in Medicare HMOs has increased 60% since 1993. These developments have complicated service delivery and financing to dual eligible beneficiaries who can now be covered in four discrete ways:

- Medicaid fee-for-service/Medicare HMO;
- Medicaid managed care/Medicare HMO;
- Medicaid managed care/Medicare fee-for-service;
- Medicaid fee-for-service/Medicare fee-for-service.

This increasingly complex set of possible combinations complicates enrollment, eligibility, claims and payment processing, third party liability, and quality oversight activities. Medicaid and Medicare laws and rules establish different requirements in these areas which present barriers to fully integrating acute and long term care and create confusion about accountability. This confusion is exacerbated as more and more Medicare HMOs offer enhanced benefits to attract enrollment. When these enhanced benefits duplicate Medicaid covered benefits, such as out-patient drugs, for those dually eligible, Medicaid programs need to restructure Medicaid capitation rates to assure no double payment for the enhanced benefits and primary care providers need to carefully monitor how dually eligible beneficiaries are accessing and using services. The growth of point of service and preferred provider arrangements may present still more approaches to integrate Medicare and Medicaid.

To truly eliminate service delivery fragmentation and coordinate care for dually eligible beneficiaries requires a careful review of what states wish to and can realistically accomplish. Given the significant differences in Medicaid and Medicare, and the differences among states in penetration and sophistication of managed care plans, demographic and geographic characteristics, marketplace availability, and political realities, each state needs to carefully determine its objectives prior to launching efforts to integrate acute and long term care. Within the broad goal to integrate care, states need to establish priorities for what they wish to achieve. For example:

- Does the state wish to include preventive and primary care objectives in the initiative? Is a goal to prevent or forestall the impact of chronic illness and disability?
- Does the state wish to create a seamless system of service delivery for those requiring both acute and long term care?
- Does the state wish to expand home and community based alternatives?
- Does the state wish to maximize Medicare reimbursement for dually eligible beneficiaries?
- Does the state seek to build managed care capacity to serve the special needs of dual eligible beneficiaries?
- Does the state wish to craft a consumer centered system with strong beneficiary support?

Most state policy makers would answer each of these questions in the affirmative. Yet, state objectives for integrating acute and long term care can conflict with one another. For example, a fully integrated financing and delivery system between Medicaid and Medicare would likely eliminate much of the capacity to maximize Medicare payments and incentives to cost shift between two payers would be eliminated in a truly integrated plan. Expecting preventive care and a full array of long term care benefits may challenge the capacity of existing plans and providers, and building that capacity may increase costs. Expanding home and community care options may require contracting with organizations without sufficient capitalization, yet using established commercial managed care organizations (MCOs) may compromise long term care expertise. Building a strong consumer centered system could jeopardize MCO and provider support.

Target Population: Who Will You Serve?

In order to determine what it wishes to achieve in integrating acute and long term care, a state must decide for whom it wishes to achieve it. For example, many state initiatives target only those elderly or disabled who are in need of long term care services. Such a decision would limit the capacity of an initiative to achieve some primary and preventive care goals. Other states target all dually eligible beneficiaries who present with a wide range of needs. Others limit programs to elderly or persons with disabilities only, while still others serve both elderly and persons with disabilities.

Determining the target population to be served is critical to program design. PACE, for example, is targeted to older people who are nursing facility-certified and provides a wide array of primary, acute and long term care services. Social HMOs, with their limited long term care benefit, are technically open to all dually eligible beneficiaries but have attracted mostly Medicare beneficiaries; Minnesota's Senior Health Options serves older dually eligible beneficiaries, while most of the New England states seek to serve both

older and younger dually eligible beneficiaries

Dually eligible beneficiaries account for about 16-17% of enrollees in both Medicare and Medicaid programs and account for between 30-35% of each program's expenditures. The population tends to be in greater need of health services, with dually eligible beneficiaries more likely to have chronic or serious illnesses. Using the Medicare Current Beneficiary Survey, HCFA has developed a profile comparing dually eligible beneficiaries to Medicare-only beneficiaries. The following chart summarizes some key distinctions between the groups.

	<u>Dually Eligible Beneficiary</u>	<u>Medicare-only</u>
Female	66%	55%
Live Alone	34%	24%
Reside in Institutions	24%	2%
Self Report Poor Health	17%	8%
No regular source of call	30%	20%
Used emergency room last year	33%	18%

While these characteristics draw a sharp contrast between large groups, characteristics will further differ among the many sub-populations that comprise dually eligible beneficiaries, and states should examine closely the specific needs of the sub-populations they seek to serve.

System Design: How Will You Serve Dually Eligible Beneficiaries?

Once a state identifies its target population and determines its goals for integrating acute and long term care services, questions need to be addressed regarding how to structure the integration of finances and service delivery. Initially, states must grapple with the decision about whether Medicaid should allow voluntary enrollment or require dually eligible beneficiaries to enroll in managed care. Some states initiate programs on a voluntary basis to develop consumer and other support for the program and to allow time for needed infrastructure to develop. Other states begin their programs with mandatory enrollment, fearing that voluntary programs would yield insufficient enrollment, making it difficult for the state or plans to invest sufficient resources needed to fully develop programs. Medicare's freedom of choice requirements make it possible for a beneficiary to choose any Medicare provider even if enrollment in Medicaid managed care is mandatory. This complicates the integration of financing and service delivery. However, if a beneficiary elects to receive services from a plan that is both Medicare and Medicaid authorized, integration of services may be more likely. Though freedom of choice issues are often the most difficult to make, many others are equally important. What will the range of services include? Will the program operate statewide?

States and site-based programs have taken varied approaches to these and other questions that ultimately determine the degree of integration that will be achieved. For purposes of

discussion, we have chosen to focus the discussion in this paper on six states and one site-based program, all of which have achieved or hope to achieve some degree of Medicare/Medicaid integration. We have selected these programs because of the variety of approaches they represent, not because they are the only or necessarily the best examples of integration. They are described here and summarized on Table 1.

ALTCS (Arizona Long Term Care System)

ALTCS is a mandatory Medicaid managed care program targeted to people whose needs qualify them for long term care services. The program is administered by the Arizona Health Care Cost Containment System for elderly people and people with physical disabilities and through the Department of Economic Security for people with developmental disabilities. In ALTCS, Medicaid acute, long term care and behavioral health services are integrated, but Medicare is not explicitly included as part of the program design. However, the program achieves a degree of integration at the contractor level, because Medicare services are usually delivered through that contractor and reimbursed on a fee-for-service basis. Beneficiaries tend to receive all of their services from the Medicaid contractors, in part because Arizona's Medicaid waiver allows the State to deny Medicare cost sharing to providers who are not part of the ALTCS contractor's network. This creates an incentive for beneficiaries to remain in network for all services, but HCFA has stated that it will not approve such arrangements in the future because they restrict Medicare choice.

Colorado Integrated Care and Financing Project

Colorado received Medicaid and Medicare waivers on July 1, 1997 to enroll all Medicaid beneficiaries, including those who are dually eligible, in an integrated managed care plan in Mesa county. The State will contract with Rocky Mountain HMO, which has an existing Medicare contract with HCFA. This voluntary program will combine Medicare and Medicaid health and long term care services at the HMO level. Mental health services and services for developmentally disabled beneficiaries will not be included. The program is expected to enroll 7,800 Medicaid beneficiaries (AFDC, SSI and categorically needy beneficiaries) including 1,200 who are dually eligible. Long term care services will be managed through a subcontract with the Mesa County Department of Social Services, a single entry point agency,¹ which is currently responsible for managing Medicaid community based waiver services and state funded long term care services.

¹The single entry point agency is a county agency responsible for nursing home preadmission screening function, and case management for the state's Medicaid home and community based services waiver program and state funded residential and in-home services.

MaineNET

MaineNet is being developed for three rural counties in Northern Maine, areas with very low levels of managed care penetration. The State will require Medicaid enrollees who are elderly and those who are younger and disabled to join an Integrated Service Network (ISNs) for all Medicaid funded acute and long term care services. ISNs may be HMOs or groups of providers organized for the purpose of bearing risk. The State has proposed in its waiver application that Medicare services be delivered through a primary care case management component. The same PCP would order both Medicaid and Medicare services, and the Medicare services would be reimbursed on a fee-for-service basis. As an incentive, dually eligible beneficiaries who agree to use the Medicare PCCM component of MaineNET would receive points monthly, redeemable for supplemental benefits not otherwise covered, such as eye glasses.

MSHO (Minnesota Senior Health Options)

Minnesota was the first State to receive Medicaid and Medicare waivers to explicitly integrate acute and long term care for dually eligible elderly people. In January 1997, the State implemented MSHO in seven counties in the Minneapolis - St. Paul area. The program offers an integrated package of Medicaid and Medicare acute and long term care services through a choice of three managed care plans. Enrollment is voluntary. MSHO is the only program approved to date by HCFA that provides for state management and oversight of both Medicaid and Medicare through a single contract. Plans are at risk and the State has developed two risk sharing arrangements. Plans are responsible for the first 180 days of nursing home costs. After 180 days, nursing homes are reimbursed fee for service and the plan continues to provide all services. MSHO has multiple rate cells to create incentives for plans to use residential and home and community based services over institutional services.

OHP (Oregon Health Plan)

Oregon began implementation of its statewide, mandatory Medicaid managed care program, the Oregon Health Plan, in 1994. In 1995, older people and people with disabilities were added to the program. In most cases, OHP covers all Medicaid primary and acute care services through a choice of capitated plans. Most long term care services are provided on a fee-for-service basis when needed, and OHP contractors are expected to coordinate their primary and acute services with those provided by the separate long term care system. Behavioral health services are provided either through OHP plans or through separate contractors, depending on the region. Oregon developed a special approach to dually eligible beneficiaries as part of the design of the OHP. Four of the six Medicare HMOs in Oregon have OHP contracts, enabling dually eligible beneficiaries who choose those plans to receive both Medicaid and Medicare services through a single company. Those choosing an OHP plan that is not a Medicare HMO receive their Medicare benefits on a fee-for-service basis through their Medicaid plans. Like Arizona, Oregon does not pay Medicare cost sharing if beneficiaries receive Medicare services

outside of OHP networks.

PACE (Program of All-Inclusive Care for the Elderly)

PACE is the longest standing integration program, having begun with San Francisco's On Lok program in 1983. A national demonstration program was launched to replicate On Lok's approach, and the first site opened in 1990. PACE integrates acute and long term care services for older people who are nursing facility-eligible in small, provider-based sites. Day health centers provide the locus of care, which is highly integrated through the use of Interdisciplinary Teams. Each site negotiates a Medicaid capitation with its state and receives a Medicare capitation from HCFA. The program is voluntary. As of July, 1997, twenty-five fully or partially developed PACE sites had been implemented in fourteen states. The federal Balanced Budget Act of 1997 includes provisions to grant the program permanent status and expand the number of available sites.

Texas Star+Plus

The State has submitted its waiver application to implement Star+Plus, a pilot project in the Houston area that will enroll 60,000 aged, blind and disabled beneficiaries, including 31,000 dually eligible beneficiaries, into managed care plans with a combination of §1915(b) and (c) waivers. The State has selected three managed care organizations (MCOs), two of which have or will have established Medicare risk mechanisms. (One is a Medicare HMO and the other has been selected by HCFA as a Medicare Choices demonstration site.) Enrollment will be mandatory for Medicaid services and voluntary for Medicare services. Those choosing to include their Medicare services will choose one of the two Medicare risk MCOs. The benefit package includes the full range of Medicaid acute and long term care services. Under the current state Medicaid plan, prescription drugs are limited to three prescriptions per month. As an incentive, dually eligible members who include their Medicare services will receive an unlimited drug benefit.

New approaches beyond those taken by the seven programs highlighted here are likely to emerge in the next few years. With both The Robert Wood Johnson Foundation and HCFA sponsoring demonstrations in this area, this paper is intended to help states clarify their goals, break integration into its component parts, and develop innovative approaches to integration which meet the unique needs of their own states and the dually eligible beneficiaries they serve.

Table 1. Summary of Selected Programs Serving Dually Eligible Beneficiaries

	Target Population	Scope of Service	Voluntary or Mandatory	Medicare Approach	Statewide?	Status
Arizona Long Term Care System	Nursing facility eligible elderly, physical or developmentally disabled	Primary, acute and long term care	Mandatory for Medicaid	Usually coordinated on FFS basis	Yes	Operating since 1989
Colorado Int. Care and Financing	All Medicaid, including dually eligible	Primary, acute and long term care	Voluntary	Capitated through Medicare HMO	No	Waiver approved July 1997
MaineNET	Elderly and disabled, including dually eligible	Primary, acute and long term care	Mandatory for Medicaid	Primary Care Case Managed	No	Waiver recently submitted
Minnesota Senior Health Options	Elderly dually eligible	Primary, acute and long term care	Voluntary	Capitated through Medicare waiver	No	Operating since 1997
Oregon Health Plan	All Medicaid, including dually eligible	Primary and acute	Mandatory for Medicaid	Capitated through Medicare HMO; or FFS	Yes	Operating since 1994 (with dually eligible phased in 1995)
PACE	55+ years, nursing facility eligible	Primary, acute and long term care	Voluntary	Capitated through Medicare waiver	No	At On Lok since 1983; replication sites since 1990
Texas Star+Plus	Elderly and disabled, including dually eligible	Primary, acute and long term care	Mandatory for Medicaid	Capitated through Medicare HMO or Medicare Choices MCO; or FFS	No	Waivers submitted

B: Laying the Conceptual Framework

What is integration? The word has generated much excitement and controversy in recent years, yet it remains largely a catchword, meaning different things to different people. Social HMOs, Minnesota Senior Health Options, PACE sites and the Arizona Long Term Care System are all commonly cited as examples of integrated care, yet they serve different populations, include long term care services to different degrees, and enjoy varying amounts of success in actually blending Medicare and Medicaid services at the level of the individual beneficiary.

It may be useful to think about integration as an end point on a continuum, with the other end representing completely fragmented care. Along the continuum fall the various existing efforts to make Medicare and Medicaid work better for dually eligible beneficiaries.



Full integration is extremely difficult to achieve, and may or may not be necessary, depending on a state's program goals. Full integration of Medicaid and Medicare can be broken into particular dimensions, and states can decide which dimensions are most important and feasible to pursue, given their goals, program development resources, existing state and commercial infrastructure and a host of other variables. Successful integration of any dimension results in an incremental move to the right on the continuum.

We have identified six dimensions of integration, each of which comes with a set of trade offs and technical challenges. Section C provides a detailed discussion of each dimension, described briefly here:

- **Scope and Flexibility of Benefits:** To what extent is the full range of Medicaid and Medicare services integrated into the program? Is long term care included in the package of services (as in MSHO) or is it coordinated through case managers (as in the Oregon Health Plan)? Are Medicare services included directly in the program (as in PACE sites) or are they coordinated through a Medicaid plan (as in the Arizona Long Term Care System)? Are any services (such as mental health) carved out to separate organizations? Does the integrated service package simply combine and replicate Medicaid and Medicare service arrays, or are services more flexible and able to meet individual needs?
- **Delivery System:** How integrated is the network of providers that makes up the service delivery system? Is the entire range of services represented within the system, including home and community-based, residential and social service providers? How are network services coordinated with those provided outside the network?

- **Care Integration:** Are Medicare and Medicaid services actually integrated at the level of clinical practice? Does a centralized patient record exist? Is case management or some other mechanism used to integrate multi-disciplinary services? Is a Primary Care Practitioner or team leader accountable for clinical outcomes?
- **Program Administration:** Has contract oversight been unified, or do systems contract with separate entities for Medicaid and Medicare? Have operating systems been integrated? For example, have Medicaid and Medicare enrollment processes been combined into one? To what extent is data collected and analyzed by a single entity?
- **Quality Management and Accountability:** Has a single entity been identified as accountable for beneficiary outcomes, or do quality efforts focus on the individual services offered by the various providers within the system? Have Medicaid and Medicare quality requirements been integrated into a single set?
- **Financing and Payment:** Does the manner in which Medicaid and Medicare payments are made maximize flexibility of benefits and minimize opportunities for cost shifting? To what extent are the state and HCFA acting as a single purchaser with common financial incentives?

As a practical matter, few if any states will be able to construct fully integrated programs from the outset. The dimensions described here and explored in greater detail in the next section become useful for prioritizing and organizing program development in any given state, either as part of a transition to integration, or as a decision to focus resources on the dimensions that most fully advance program goals, are manageable given public and private capacity, are possible within state and federal policy, are politically feasible and are achievable within a state's time table.

C. Key Dimensions of Integration

C-1: Scope and Flexibility of Benefits

A key goal of integration is to create comprehensive and flexible benefits that allow creative use of home- and community-based care to avoid preventable admissions to hospitals and nursing homes. The full range of Medicaid and Medicare benefits are capitated to a single contractor, who may use the pooled funding to provide needed benefits, whether or not they are specifically covered in fee-for-service. This approach was first fully implemented at PACE sites (Program of All-inclusive Care for the Elderly), and in early 1997, Minnesota became the first state to use the approach when it began enrolling elderly beneficiaries into its Senior Health Options program (MSHO).

The opportunity to integrate care stems in part from the breadth of the principal contractor's responsibility: a contractor can not integrate acute and long term care if only responsible for one or the other. For example, by design, the Oregon Health Plan (OHP) does not include long term care services. When an OHP member requires long term care services, the contractor is responsible for coordinating its primary and acute care services with the long term care services delivered through a separate service system. The expectation is not that acute and long term care will be integrated, but rather that they will be closely coordinated as the need arises.

Variation Across Programs

Of the seven programs featured throughout this paper, only two (MSHO and PACE) offer the full range of Medicare and Medicaid benefits through a single contractor for all members. The other five have or are constructing programs in which a significant amount but not all care is delivered through a single contractor. As the chart at the end of this section shows, all seven include Medicaid primary and acute coverage, but they vary in their approaches to Medicaid long term care, Medicaid behavioral health, and Medicare services.

Medicaid Long Term Care

Medicaid long term care services are included in all of the selected programs except Oregon. This usually occurs on a fully capitated basis, though partial capitation of long term care is possible. In the MSHO program, for example, Minnesota has limited its contractors' financial liability for nursing facility services to 6 months, after which the contractor continues to be responsible for care but is reimbursed on a fee-for-service basis. While this raises implications for rate design and potential cost shifting (addressed in section C-6), contractors remains responsible for overseeing the long term care services, and have a continuing opportunity to integrate those services with others.

Medicaid Behavioral Health

States also take a variety of approaches to Medicaid behavioral health services. In conjunction with its Integrated Care and Financing Project (ICFP), Colorado will continue an existing mental health carve out program in the demonstration area, paying a capitation to a separate contractor for mental health services only. Although the ICFP contractor and the mental health contractor will coordinate their services, integration will be more challenging with organization-to-organization barriers to overcome. In Maine, pursuant to an agreement between the Medicaid agency and the mental health agency, inclusion of behavioral health will vary by sub-population. At least initially, elderly beneficiaries will receive mental health services through the MaineNET contractor, but adults with disabilities under 65 years of age will receive mental health services through a separate carve out program being planned by the mental health agency. In Oregon, all Medicaid mental health services must be provided through the county mental health provider systems.

Because dually eligible beneficiaries receive mental health benefits from both Medicaid and Medicare, and because mental health carve outs are so prevalent in Medicaid, this service is more prone to fragmentation for dually eligible beneficiaries than others. For example, a dually eligible member enrolled in a Medicare HMO in Oregon must use the Medicare HMOs mental health network for Medicare mental health services and a different network (the county's) for Medicaid mental health.

Medicare

The degree to which Medicare is included varies greatly across programs. At PACE sites and in Minnesota and Colorado, the principal contractor is responsible for the full range of Medicare Part A and B services, and is paid on a capitated basis directly from HCFA. Oregon and Arizona have constructed programs in which the principal contractor almost always coordinates Medicare services, but Medicare reimbursement is only capitated to a subset of Medicaid contractors who happen to be Medicare HMOs.

To date, three major approaches to Medicare have been developed:

- **Use of Existing Medicare HMO Contract:** If the principal Medicaid contractor also has an existing Medicare HMO contract with HCFA, dually eligible members may simultaneously enroll in the contractor's Medicare and Medicaid products, and the contractor ensures that only one Primary Care Practitioner (PCP) is responsible for the full range of services available through both products. This approach depends upon the beneficiary's willingness to join the contractor's Medicare HMO, since enrollment in Medicare managed care is entirely voluntary under federal law. This approach is used extensively in Oregon and to a lesser extent in Maricopa County, Arizona, and is proposed for Colorado's ICFP;
- **Fee-for-Service Medicare:** If the principal Medicaid contractor does not have a Medicare HMO contract, the contractor may still integrate Medicare services into the

total package of care overseen by the primary care practitioner (PCP), and the PCP or the contractor may bill for the Medicare services on a fee-for-service basis. This approach depends on dually eligible beneficiaries voluntarily receiving their Medicare services through the same contractor, since they have the freedom to receive Medicare services from whomever they like. Arizona and Oregon have used a strong financial incentive to make this approach work: Medicare cost sharing is only available to members who receive Medicare services or authorization for such services from network providers. HCFA will not approve this arrangement in the future, so states must find other incentives to encourage dually eligible beneficiaries to stay in network with their Medicare benefits. MaineNET has proposed awarding points to members who stay in network; Texas is offering an expanded drug benefit; and

- Capitated Medicare to entities other than Medicare HMOs: PACE sites and MSHO have designed programs in which Medicare capitation is paid to a contractor which is not necessarily a Medicare HMO. This approach allows a capitated Medicare payment to be made to an entity that may not be interested in or able to obtain Medicare HMO certification, such as a community-based provider or a Medicaid MCO. Medicare waivers are required for this approach, as explained below.

Scope of Responsibility Differentiated from Scope of Capitation

The arrangements highlighted in Table 2 point out that degrees of integration can occur without full capitation of Medicaid and Medicare. The range of benefits that is within the principal contractor's responsibility is at least as important as whether or not they are capitated. Benefits may not be as flexible if they are not capitated, but if the contractor is at least responsible for a broad range of benefits, the contractor can work toward integrating those benefits, regardless of how they are reimbursed. At pre-PACE sites, for example, providers begin operating PACE-like programs before becoming fully certified as PACE sites. Until PACE status is achieved, Medicaid reimbursement to the site occurs on a partially capitated basis and Medicare reimbursement occurs on a fee-for-service basis, but the clinical integration of care can still occur through the interdisciplinary team at the pre-PACE site, just as it would at a bona fide PACE site. Similarly, Arizona Long Term Care System contractors are usually able to include Medicare services in their total plan of care for members, even if they are reimbursed on a fee-for-service basis.

Legal Issues Related to Scope of Benefits

Waivers are likely to be required to implement programs that offer the full scope of Medicare and Medicaid services. Medicaid waiver requirements are well known by now, but a number of legal issues pertaining to Medicare have only recently been explored with the submission of state Medicare waiver requests. Medicare issues include the following:

- *Medicare Capitation or Alternative Payment.* As noted above, states seeking to construct programs in which Medicare services are capitated to an entity other than a Medicare risk contractor may need a Medicare waiver under §222, though the number and type of entities eligible for Medicare risk contracts is expected to expand with passage of the federal budget agreement. Section 222 waivers are also required to construct Medicare payment alternatives to the AAPCC, whether or not a Medicare risk contractor is used. For example, Colorado required a §222 waiver even though it has selected a Medicare HMO, because it will not be using the traditional AAPCC to calculate Medicare rates; and
- *Medicare Lock-In to Network.* In Medicare HMOs, beneficiaries are required generally to use network providers (on a month-to-month basis), and this requirement has also been applied in Medicare waiver programs like MSHO. As described above, Arizona and Oregon created a Medicare lock-in of sorts without a Medicare waiver by paying Medicare cost sharing only to their Medicaid contractors, but this approach will not be approved by HCFA in future Medicaid waiver requests.

**Table 2. Scope of Services Delivered through Principal Contractor
in Selected Programs**

	Medicaid Primary/ Acute	Medicaid Long Term Care	Medicaid Behavioral Health	Medicare	Waivers Received or Requested
Arizona Long Term Care System	Yes	Yes	Yes	Usually	1115 received
Colorado Integrated Care/Finan.	Yes	Yes	No	Always	1115 and 222 received
MaineNET	Yes	Yes	Sometimes	Sometimes	1115 requested
Minnesota Senior Health Options	Yes	Yes	Yes	Always	1115 and 222 received
Oregon Health Plan	Yes	No	Sometimes	Usually	1115 received
PACE	Yes	Yes	Yes	Always	1115 and 222 received
Texas Star+Plus	Yes	Yes	Yes	Sometimes	1915(b) and 1915(c) requested

C-2: Delivery System

Approaches to Delivery Systems

The promise of managed care for dually eligible beneficiaries rests in the opportunities to reinvent systems of care for older people, providing more consumer centered care, developing creative alternatives to nursing home care and assuring continuity as individual needs change. Integrating delivery systems is a vehicle to fulfill this promise but it requires bridging the philosophy, history and perspectives of the Medicare and Medicaid programs. The different origins and foundations of these programs cast long shadows for those who attempt to reconcile their distinctive features and differences to design programs based on their similarities. Although this challenge occurs along each of the managed care dimensions addressed in this paper, it is critical to the development of delivery systems to integrate services. Medicare and Medicaid view and select delivery systems from very different perspectives. Medicare sets conditions of participation for managed care networks and contracts with all networks which meet those conditions. The requirements are standard across states although HCFA has limited authority to enter into reimbursement arrangements with organizations that do not fully meet the conditions.

State Medicaid agencies set conditions for managed care organizations, often in conjunction with state Insurance Departments and/or Health Departments. Most state Medicaid agencies issue a “request for proposals (RFP)” to select MCOs although states may also use a certification model.² RFPs contain specific requirements and timetable for contractors to submit proposals. States may contract with all bidders meeting the requirements or limit the number of contracts based on a combination of price and/or service. Once qualified, states might negotiate price with each qualified bidder. Certification approaches are more similar to Medicare since there is no time limitation and states agree to contract with all organizations meeting the standards set by the Medicaid agency. HCFA’s rules generally require that states contract with organizations with at least 25% commercial enrollees, however, states may obtain waivers of this composition requirement. State rules also include standards for network adequacy, access, complaint procedures, fair hearings, and quality improvement.

Unlike Medicare, Medicaid purchasing decisions are made by the state and individual services or groups of services may be excluded from the contract. Purchasing decisions flow from the goals of the managed care program and requirements to offer beneficiaries a choice of plans or delivery systems. As a result, there is greater variation among the scope of services delivered and the organizations contracting with state Medicaid programs. However, legislation pending in Congress may significantly change Medicare contracting patterns by allowing organizations that are similar to Medicaid plans to routinely serve Medicare beneficiaries.

² For more information, see *Medicaid Managed Care: A Guide For States* , Second Edition. Volume II. May 1995.

State options for integrating services depends in large part on the state's managed care market. States with significant private managed care and/or Medicare managed care enrollment have more organizations to consider while developing Medicaid programs. States with minimal private or Medicare enrollment will have to stimulate the formation of organizations capable of accepting risk and organizing appropriate provider networks.

Role of Beneficiary Choice

The extent of any integrated managed care network will depend in part on beneficiary choice. As described elsewhere, Medicare beneficiaries always retain the right to receive Medicare services on a fee-for-service basis, while Medicaid beneficiaries may be subjected to mandatory enrollment. Medicaid managed care programs using Medicare HMOs may fail to fully integrate services because beneficiaries may decide to receive Medicare services through the fee for service system. However, effective enrollment counseling and creative incentives may encourage dually eligible beneficiaries who choose to remain in the Medicare fee for service system to receive all Medicare services through providers of the Medicaid managed network without enrolling in a Medicare managed care plan. If beneficiaries choose a network because their providers are included, and accept the rationale of managed care and continuity of care by using network providers, coordination is easier. Conflicts can be minimized if the member fully understands the philosophy of the organization and the process for accessing and coordinating services. Effective member orientation procedures can support coordination of care by stressing importance of using network providers. But the reality remains that Medicare beneficiaries retain the choice to go out of network for care. Therefore, States need to develop effective oversight systems to track out of network utilization.

Medicare Risk Contractors

In June 1997, HCFA had approved 283 risk contracts with a total enrollment of over 4.7 million beneficiaries. While the number of dually eligible beneficiaries enrolled in these programs is not known, the extent of the contracts offers opportunities in several states to use Medicare risk contractors to deliver Medicaid acute and long term care services. Contracting with Medicare risk contractors allows states to develop options through which dually eligible beneficiaries can receive the full scope of Medicare and Medicaid services. However, some states' purchasing laws may not allow those states to limit bidders to MCOs that have Medicare contracts and exclude MCOs that do not enroll Medicare beneficiaries. Where it is possible, there is no guarantee that all Medicare risk contractors will be willing to contract with Medicaid or that they will be interested in assuming risk for long term care services. Further, because Medicare payment rates vary by county, Medicare risk contractors have not offered their plans statewide, which means states with statewide programs could not use them as the sole vehicle.

As of this writing, Medicare risk contractors must be federally qualified HMOs or competitive medical plans, but eligible entities are expected to multiply with passage of the federal Balanced Budget Act of 1997, which includes provider sponsored organizations (PSOs), preferred provider organizations (PPOs) and other entities as

qualified Medicare risk contractors. Medicare risk contractors in urban areas must have at least 5,000 commercial enrollees. Currently, no more than 50% of total enrollment in the geographic area covered by the Medicare contract may be Medicare and/or Medicaid beneficiaries, but the 50/50 composition rule is also likely to change following enactment of the federal Balanced Budget Act of 1997, which replaces it with enhanced quality measures. Plans must hold an annual open enrollment period for at least 30 days. Medicare HMOs must maintain an internal complaint procedure and comply with the Medicare appeals process. Regulations also contain access standards for network adequacy, travel time, location, after hours care, monitoring and continuity of care.

In June 1997, there was no Medicare enrollment in HMOs in ten states. Only ten states have more than 100,000 Medicare members. Therefore, Medicaid agencies in many states must develop a long range, phase-in strategy, limit integration to Medicaid services or seek HCFA waivers to use unique networks to deliver Medicare services.

Other managed care organizations operate demonstration programs overseen by HCFA that could be used as vehicles for developing integrated systems such as Social HMOs, MCOs participating in the Medicare Choices Demonstration, and EverCare sites. However, these demonstrations operate in a limited number of locations and, although they represent important opportunities for states in which the sites are located, they do not lend themselves to widespread replication.

Medicaid MCOs

Based on their perceived success developing managed care programs for TANF beneficiaries with organizations that are not necessarily federally qualified HMOs, some states prefer to use their own Medicaid networks as vehicles for integration. Capitated Medicare payments may be provided to Medicaid MCOs with Medicare §222 waivers, or Medicare services may be coordinated through the Medicaid network and charged on a fee-for-service basis.

Creating Networks

Integrated delivery systems should reflect the population to be served, the source and extent of financing and the scope of services. These parameters will determine the type and the expertise of providers needed. Broader parameters require increased attention to recruiting health care providers with geriatric expertise and a broader array of community providers offering traditional residential and home and community services.

States may use a range of approaches to determining network capacity. Traditional measures such as the number of providers in relation to the enrolled population and time/distance measures, may not be appropriate access measures for vulnerable populations. It is important to know whether the plan's providers are willing to care for people with chronic illness and functional or cognitive impairments and whether they have experience doing so. Wisconsin's guidelines for the Independent Care Program require that the contractor must subcontract with providers with knowledge and

experience relevant to the needs of people with disabilities. Network providers are compared to Medicaid's list of providers in the plan's service area that have historically served the enrolled population.

Beneficiaries in Oregon must have the same access to providers as non-OMAP members. Contractors must meet the community standard, but they must also be able to meet the needs of the enrolled population. Under administrative rules, contractors provide evidence that vulnerable populations have access to providers with expertise to treat the full range of medical conditions experienced by enrollees.

States need to ensure that members will have appropriate access to specialists and plans may need to make accommodations when they do not have a sufficient number of specialists in their service area. Arizona's contract requires that plans have networks adequate to provide all covered services. To meet these standards in rural areas, some plans must provide enrollees transportation to specialists located some distance from enrollees' homes. As part of the plan selection process, Oregon requires that plans describe how they will obtain specialty care and incorporates that description into each plan's contract. Some plans developed arrangements with specialists outside their service areas to comply with the requirement. When plans use specialists that are not part of the network, they must develop mechanisms to coordinate care and monitor utilization.

Moving Beyond Traditional Providers

Combining primary, acute and long term care funds in a single organization offers maximum opportunities to provide care that meets the beneficiary's need in the least restrictive, most cost effective setting. Fully integrated delivery systems must have the capacity to offer a full array of primary care, acute care, and long term care including institutional, residential, community and in-home services.

In order to offer a full range of services, networks require a diverse array of service options that afford consumers maximum choice and offer opportunities to use capitated payments flexibly to deliver the most appropriate and cost effective service. Traditional HMOs have limited experience serving low income elderly persons, particularly elderly persons with chronic functional limitations. However, since systems to deliver primary, acute and long term care are only now emerging in selected areas, systems must be created that combine the experience of health, community based systems and residential options.

Delivery systems will establish formal arrangements with providers delivering services that are covered by the capitation payment and the scope of services. These variables define the services for which the system has a legal responsibility to provide. Yet dually eligible beneficiaries may also benefit from or receive required services that are outside these parameters such as the Older Americans Act, state funded home care services and Social Services Block Grant services. Arrangements will be needed to make referrals, and monitor and coordinate services.

Depending on the network's philosophy, MCOs may use the flexibility of their capitation payment to provide services which are not specified in the scope of services but which are cost effective and appropriate for the beneficiary. For example, an MCO may pay for an exterminator to reduce health hazards in a home, a nutrition assessment to evaluate risk, or installation of a phone for someone who may need access to emergency care. Often conditions that create risk can be minimized by authorizing services that are not considered health or even traditional long term care services. MCOs may want to identify the types of related services and providers and establish working arrangements in order to expedite their delivery when appropriate.

Building Home Care Networks

Delivery systems need to combine traditional health care providers and community based long term care providers. Nursing facilities, home health agencies and durable medical equipment providers have experience with both acute and long term care, but other community providers are needed. State long term care delivery systems rely on many community organizations, which may lack health care expertise, to provide personal care, homemaker, chore services, transportation, home delivered meals, adult day care, respite care and other services. These organizations meet the standards set by state agencies operating Medicaid waiver or state funded home care programs. The services maintain the functional capacity of frail elders who have physical or cognitive impairments that limit their ability to perform activities of daily living and instrumental activities of daily living.

To build networks, MCOs can rely on their current certified home health agencies or add new organizations that provide paraprofessional or less skilled services. MCOs could either contract with individual home care and related organizations or contract with an existing network of such organizations. Contracting with individual agencies can be time consuming and difficult for MCOs used to dealing with large organizations, integrated provider networks and physician groups. In contrast, home and community providers are typically smaller, independent organizations. MCOs might consider contracting with, or "renting," the existing system in states with well-developed in-home programs rather than building a new system. Contracting with an existing home care network reduces the number of contracts that must be negotiated and monitored by the MCO. These functions can be delegated to the community case management agency. It also ensures faster start up and continuity of services for beneficiaries already receiving care. For voluntary managed care programs, beneficiaries may be more likely to enroll if they can keep their personal care attendant, homemaker or other home care provider.

There are two main functions performed in community based home care programs, a case management function and service delivery. The case management function usually includes determining eligibility for admission to a nursing home in addition to performing assessments, determining eligibility, and developing and authorizing care plans for home and community based services. State agencies perform these activities either through state field staff or contracts with a county health or social service department or an Area Agency on Aging. Some states contract directly with providers to

perform assessment, care planning and authorization functions. However, in a fee for service environment, this creates incentives to over-authorize services. As independent organizations, case management organizations generally do not have a financial interest in the services used and operate within a prescribed budget or limits on service authorizations. They in turn contract with an array of community agencies to deliver care. The case management agency is responsible for monitoring quality assurance, compliance with program standards and financial activities.

MCOs developing integrated systems must decide who will perform long term care case management functions and how the MCO will build its direct service capacity. MCOs could contract both functions to the existing home care system. Rocky Mountain HMO in Colorado has developed a contractual relationship with the Mesa County Department of Social Service to perform the case management and home care functions. Integrated service networks in Minnesota approached counties to serve as subcontractors for home and community based services.

Contracting with community care systems means resolving differences between the two systems. States with extensive home care programs award contracts to a single entity for a defined geographic area (a county or a specified service area). Multiple MCOs may operate in an area and the service area may not coincide with those of the community system. MCOs serving an entire state or a large region of a state may prefer a single contract rather than multiple contracts. Community based case management agencies could form a consortium to operate as a single entity or one agency could function as a “lead” agency responsible for further subcontracting and monitoring. An MCO could instead contract with a single organization to provide services throughout the MCOs service area. Under draft specifications, Senior Care Organizations (SCOs) in Massachusetts would be required to contract with at least one Home Care Corporation to participate in the SCOs care management team and to coordinate and monitor home and community based services. SCOs would contract with multiple home care corporations or a single corporation. Depending upon the arrangement with the SCO, the home care corporation could either cover the entire area or subcontract with other corporations to maintain the separate service boundaries. These decisions will be made by the SCO.

There are few precedents for MCOs forming home care networks. As integration models emerge, they are likely to affect the organization of home care agencies just as managed care has stimulated consolidation and network development among hospitals, physicians, nursing homes and other health providers. If the MCO retains the case management activities, contracting with an existing provider network may not be possible because there is not likely to be one organization through which to do so. An MCO could contract with an existing case management agency for administrative services involved in contracting with and monitoring local provider agencies. Over time, these provider agencies may develop horizontally integrated organizations or vertically integrated systems might expand to include them. MCOs might develop short and medium range strategies for building networks that reflect the likely market response to new opportunities created by comprehensive managed care programs for dually eligible beneficiaries.

MCOs and community organizations need to be clear about the role of each organization -- how needs will be assessed, how services plans will be developed and authorized, how the activities of the community organization will be reimbursed and the extent of shared risk, if any. Community organizations also need to know what data must be collected and reported to the MCO. Although community organizations have to account for spending and report data to state agencies managing HCBS programs, those requirements may change under managed care.

MCOs also must develop linkages to services provided through other state and federally funded programs. In addition to Medicare and Medicaid, beneficiaries in Colorado and Massachusetts will also be eligible for services under the Older Americans Act and state funded long term care programs. Because the care management process includes staff from the local case management system, beneficiaries have access to benefits and services that may be outside the Medicaid capitation payment.

Assisted Living

Residential options are also important to offer supportive settings for people who can no longer live at home or who need a supportive housing setting during periods of transition. These options include assisted living, adult family care, and board and care facilities. Assisted living is a relatively new development in most states and offers MCOs an opportunity to coordinate services in a residential setting to avoid or shorten rehabilitative stays and nursing home placements. While state licensure rules vary, assisted living facilities provide personal care, medication administration, nurse monitoring and other skilled services as well as housekeeping, meals and transportation. Services may be provided by other contractors and coordinated by the MCO or by the assisted living facility itself. Developing residential options may avoid the tendency for elders to become dependent and isolated in other long term care settings and maintain family involvement that may diminish once a person is admitted to a nursing home. Assisted living is, or will be, covered as a Medicaid service in 22 states as a 1915(c) waiver service or as personal care under the state plan. Assisted living providers are included in MCO networks in Arizona, Florida and Minnesota. Some of the potential advantages of assisted living include:

- Providing a safe, supportive environment during a transition from post acute care to recovery at home;
- Offering a setting in which HMO covered home care can be delivered;
- Depending on state assisted living licensure requirements, offering HMOs a cost effective method of delivering home care services for beneficiaries with extensive needs and offering beneficiaries residential settings when they can no longer live at home;
- Providing a supportive housing and services option for HMO hospital discharge

planners considering options for people who can not return home following an acute episode; and

- Offering a supportive residential option for beneficiaries who can no longer live at home due to the cumulative affects of chronic illness.

Relationships between assisted living and HMOs are not common and state dual eligible initiatives could be instrumental in forming these linkages. Assisted living offers a distinct advantage to Medicare HMOs serving dually eligible beneficiaries since they provide a service rich, supportive setting for beneficiaries with higher than average health care expenses. In 1998, the Medicare payment rates for dually eligible beneficiaries will be revised. Assisted living will no longer qualify for the “institutional” rate adjustment. However, the Part A rate for dually eligible beneficiaries living in assisted living will be considerably higher than for residents of nursing homes, more than offsetting the lower Part B payment that assisted living residents will receive compared to nursing homes residents.

Assisted living facilities are included in the networks of MCOs participating in programs in Arizona, Florida, Minnesota and Texas. These relationships have also been developed in the PACE program. Total Longterm Care, Inc., a PACE site in Denver, Colorado, has developed arrangements with facilities licensed as personal care boarding homes. The first contract allows PACE to support a person in a residential setting when the person can no longer live at home. The facilities are also used as a temporary setting when a caregiver is away for a period of time as well as for short term rehabilitation for members who became dehydrated or were recovering from surgery.

The PACE program has negotiated a "preferred" contract with a private pay assisted living facility through which PACE contracts for 18 units located on the first floor of the facility. The units are occupied by PACE members who are frailer than members in other settings and are more likely to be incontinent or have Alzheimer's disease. PACE sends a certified nursing assistant during the evening to help with dinner and assist residents getting ready for bed.

The Bienvivir Health Services Center, a PACE program in El Paso Texas, operates two centers that provide adult day care, rehabilitation, physician services and outpatient services staffed by a registered nurse. Emphasizing the importance of housing, the organization created a new entity, which functions as a separate corporation but has the same board members, to build and operate a 40 unit HUD 202 project. The housing project contracts with Bienvivir Health Services Center to provide services to the residents. Residents accepted for move-in may not be required to participate in PACE nor can the management limit move-in to PACE members, however, the program marketed the program to its list of members who needed housing. The Center provides services to non-PACE members that are billed through the fee for service system. The Center became a housing developer because the available housing stock was limited and lacked supportive services which left residents who were aging in place with many unmet needs. The East Boston Neighborhood Health Center, a PACE site in East Boston

Massachusetts, also own and operates an elderly housing building which includes a day care center.

Other Residential Options

Adult family care homes or adult foster care providers may also be included in programs that include long term care services. These providers offer residential settings for beneficiaries who require protective oversight, a supportive environment and personal care services. Beneficiaries with more health related needs can be served in some states if the provider meets higher experience and training requirements. Board and care facilities typically offer room, board, meals and housekeeping services. Some states consider board and care the equivalent of assisted living. In addition, facilities in which personal care and health services are delivered through private arrangements between the resident and an outside home health or other agency may not be licensed.

Coordinating Network Providers: Avoiding Internal Fragmentation

Simply forming an expanded network may not insure that services are integrated. MCOs responsible for serving frail beneficiaries need to develop three levels of coordination. First, mechanisms are needed to coordinate services from multiple providers during an acute care episode. Second, screening activities can be devised which identify beneficiaries with chronic conditions and develop disease management protocols to maintain health and functioning. Finally, still other mechanisms are needed to manage delivery long term care services from multiple providers - personal care, home delivered meals, adult day care - as well as to connect primary care professionals with long term care services. The broad range of needs among members of an integrated system challenges MCOs to implement processes in a manner that supports the goals of integration. Failure to address the pitfalls of coordinating services among network and non-network providers can undermine the reason for implementing the program.

The Independent Living Services at Loretto in Liverpool, New York, a large organization which also operates a pre-PACE program, felt it was necessary to create a system within a system in order to focus care on participants. With its own transportation department, home health agency, long term home care and medical day care departments, managers found it difficult to coordinate services if staff were tied to organization units outside control of the PACE staff and served clients in multiple programs. Staff providing care did not become as familiar with the residents and develop an awareness of the subtle changes as they would if they spent all or most of their time with participants. Organizing their model, managers found that control of care and the staff who deliver it was important. Staff were identified to serve only the participants and in effect, the program developed its own capacity to provide services that previously could have been provided by separate units within Loretto's integrated system.

States need to look beyond the components of a network to determine how the MCO manages and coordinates providers within its network.

Table 3: Comparison of Delivery System Features in Selected Programs

State	Primary Contractors	Location of Case Management	Network Includes Home Care Providers?	Network Includes Residential Providers?
Arizona Long Term Care System	Mix of counties and private MCOs	Primary Contractors	Yes	Yes
Colorado Integrated Care and Financing Project	Medicare HMO	County single entry point agency, through subcontract with primary contractor	Yes	Yes
MaineNet	Medicaid MCOs and/or provider consortia	Initially, single entry point agency for members using LTC	Yes (Proposed)	Yes (Proposed)
Minnesota Senior Health Options	Mix of Medicaid MCOs & Medicare HMO	Varies - primary contractors and/or county agencies	Yes	Yes
Oregon Health Plan	Mix of Medicaid MCOs and Medicare HMOs	Primary contractors and community LTC system	NA (LTC remains FFS)	NA (LTC remains FFS)
Texas Star+Plus	Medicaid MCO, Medicare HMO, and Medicare Choices Contractor	Primary contractors	Yes	Yes
PACE	Non-profit providers	Primary contractors	Yes	Varies

C-3: Care Integration

The tools and methods to develop integrated delivery systems are most appropriately judged at the level of clinical practice. When all is said and done, have these systems transformed the delivery of care and improved care for dually eligible beneficiaries? What approaches have been found effective in re-directing the system from a provider-specific orientation to a holistic approach to care management and delivery? In this section, we consider three practices for enhancing integrated care to dually eligible beneficiaries:

- Assignment of a Primary Care Provider;
- Use of a centralized patient record; and
- Care management.

These practices shift the system from its focus on provider-specific care to an integrated, interdependent network of resources. When effective, these practices help place the beneficiary at the hub of the integrated network and allow care needs to drive the system. Care needs are defined in relation to each other and are seen as interdependent. This requires client assessments to be objective and independent of the financial implications. This is in marked contrast to a “unit” of service orientation which isolates and evaluates clinical, social, and functional services needs of clients and renders the care in fragmented and disconnected fashion.

Assignment of a Primary Care Provider or Team Leader

All the states and PACE include features requiring beneficiaries to select a primary care provider or team leader who coordinates Medicaid and Medicare services in cases where both services are provided under the umbrella of the same managed care organization. Each of these programs have mechanisms to control the use of out-of-network Medicare services, thus enhancing opportunities to fully integrate service provision.

In Maine, dually eligible beneficiaries will have the option of having their Medicare benefits managed through MaineNET via a Medicare primary care case management, under which the PCP assigned for MaineNET Medicaid benefits would also act as a gatekeeper for Medicare benefits. Alternately, dually eligible beneficiaries may choose to continue to receive Medicare services out-of-network. Members choosing to have their care coordinated by a single PCP will accrue points which can be used to redeem non-covered services, such as eyeglasses.

Through lock-ins and withholds on the state-share of Medicare co-payments, states are attempting to reduce movement outside the network for Medicare services under their integrated delivery programs. However, HCFA has stated that it will not permit States to restrict dual eligibles freedom of choice and withhold cost-sharing. Service integration at the level of clinical practice, therefore, will depend in large part on the ability of the plan to attract and retain beneficiary allegiance to a single PCP, with or without mandated restrictions.

Use of a Centralized Medical Record

Core to the notion of integration is the ability of service providers to access timely and complete information regarding a beneficiary's health status, service use and progress. The logistics of achieving this goal are enormous and, with the exception of the PACE model, have not been fully realized. The On Lok PACE site recently received a grant from the Hartford Foundation to develop an electronic record which could be accessed by providers within the network caring for the same member. While visions of an electronic medical record persist, states have taken incremental steps to facilitate the exchange of clinical data among a broad array of community-based and institutional service providers.

The managed care contractor for the Colorado project is developing an automated record that the PCP and community providers can access through a secure internet. The record, which can be read only by a beneficiary's providers, includes assessment data, care plans, service encounters and progress notes. MaineNET and Texas Star+Plus require contractors to have long range plans for centralizing their medical records-keeping systems to promote information sharing among care providers and settings of care. Methods for sharing assessment data, available on all beneficiaries served in the state's long term care system, are being developed to assist the PCP in meeting the needs of members. Medicaid record requirements in Arizona, Minnesota and Oregon focus at the provider level without stipulating how records are to be shared among a beneficiary's providers.

Underlying the development of shared medical records are issues pertaining to the protection of beneficiary confidentiality. These protections relate not only to the integrity of the medical record itself but to the protocols for releasing information to practitioners caring for the beneficiary. The movement to centralized medical records must be considered with respect to placing restrictions on the types of information which can be released and the need for beneficiary consent.

Care Management

Dually eligible beneficiaries are diverse in their care needs. Many will require only preventive and acute care while others will need intense intervention due to chronic and debilitating conditions, lack of family supports, and cognitive impairments. Integration requires that programs move beyond a service-specific focus into the management of a beneficiary's total care needs.

While it is widely believed that care management contributes to improved outcomes, no single model has emerged. The PACE program is best known for its care management approach. An interdisciplinary team of qualified professionals and paraprofessionals is responsible for assessing the needs of potential and enrolled participants and for authorizing, developing, implementing, monitoring and evaluating participant care plans. Care management is further facilitated through a physical site which serves as the center for coordination and provision of a full-range of services (e.g., primary care services,

social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals).

Colorado represents a variation of the centralized PACE model with the creation of a care coordination team composed of staff of the managed care contractor and care managers from the state's single point of entry for long term care services. By bridging the expertise of the acute and long term care delivery systems, the team offers a holistic perspective on client assessment, care planning and management. A geriatric team at the managed care organization further supports the assessment and care planning process.

Texas Star+Plus screens all members to determine the need for care coordination services. Members with complex needs are assigned a care coordinator who, in Medicaid-only plans, also facilitates coordination with Medicare providers to the extent possible.

Maine, Minnesota and Oregon distinguish between care coordination and more intensive case management services. Through the assignment of either an individual or function, care coordination is provided to all members to assist in accessing the delivery system, arrange appointments or advise PCPs on the availability of community resources. The managed care organization in these states is expected to develop tools and processes for assessing members for complex care needs requiring more intensive management of services across providers and settings of care. The use of interdisciplinary teams are encouraged but their composition is not defined.

Members of Arizona's Long Term Care System are each assigned a care manager who meets with them at regular intervals to assure needs are being addressed. The same care coordinator may also provide intense case management services for persons with complex service needs. For the most part, case managers have no explicit authority or responsibility to coordinate Medicare services except where members are enrolled in the one plan which contracts with both Medicaid and Medicare.

A more elusive aspect of care management is the extent to which the beneficiary is integrated into the process. Programs are quick to point out the right of consumers to refuse treatment and services but are sometimes less clear regarding their authority to direct care planning options. PACE draft standards refer to a participant's right to self-determination in making decisions about his/her care. In situations where a participant opts for care not meeting accepted standards of practice, the team must document that this decision is a fully informed decision on the part of the participant. MaineNET identifies the beneficiary as a member of the interdisciplinary team but fails to establish precedent for how to resolve inevitable conflicts in decision-making among team members. Without prescribing an approach for resolving these conflicts, the bidding process will require potential contractors to define their expectations for how the process will work.

Table 4 summarizes the discussion in this section.

Table 4. Approaches to Care Integration in Selected Programs

	PCP Assignment	Centralized Medical Record	Care Management
AZ Long Term Care System	Single PCP for Medicare and Medicaid services	Provider-level medical record requirement.	Generally, separate case managers for Medicare and Medicaid
CO Integrated Care and Financing Project	Single PCP for Medicare and Medicaid services	Automated record accessed through a secure internet	Care coordination team required
MaineNET	Single PCP for Medicare and Medicaid services	No current requirement; MCO must document plans to develop	Members assigned care partner; intensive care management/ team based on need.
MN Senior Health Options	Single PCP for Medicare and Medicaid services	Provider-level medical record requirements	Care coordination function required; intensive care management/team based on need.
OR Health Plan	Single PCP for Medicare and Medicaid services	Provider-level medical record requirements	Care coordination function required; intensive care management/team based on need.
PACE	Single PCP for Medicare and Medicaid services	Single medical record	Care coordination team required
Texas Star+Plus	Single PCP for Medicare and Medicaid when in same plan.	Plans required to have centralized medical record in PCP office.	Members are screened to determine the need for a care coordinator; intensive case management provided to persons with complex needs. In Medicaid-only plan, care coordinator facilitates coordination with Medicare to the extent possible.

C-4: Program Administration

The manner in which a program is administered will determine the ease with which certain processes and systems can be integrated and in turn facilitate integration of services. We have highlighted three administrative issues that are particularly important to address as states contemplate integrating care: 1) the manner in which contracts are administered; 2) the process for enrollment; and 3) the manner in which data is reported. These vary significantly across the six programs we have highlighted in this paper.

Contract Administration

A fundamental challenge of integrating Medicaid and Medicare is overcoming the diffused responsibility and authority between the two programs. HCFA, directly and through its agents, administers the Medicare program, while states administer their Medicaid programs. Contractors are accountable to HCFA for Medicare services and to states for Medicaid services. This is the case in programs where attempts have been made to coordinate Medicaid managed care programs with Medicare HMOs, such as in Oregon. In Oregon, contractors who provide both Medicaid and Medicare services on a capitated basis maintain contracts with the State of Oregon for Oregon Health Plan (Medicaid) products, and separate contracts with HCFA for Medicare HMO products. As the State, HCFA and the Medicare HMOs have worked to align the two systems, inconsistencies and overlapping requirements have been difficult to overcome because no single entity is empowered to make decisions. Efforts to make two programs look and feel like one for dually eligible beneficiaries are compromised. For example, dually eligible beneficiaries enrolling in Medicare HMOs in Oregon receive two member cards (one for the OHP product and the other for the Medicare product) and two member handbooks, and are usually enrolled in the two products with different effective dates. This has not been cited as a problem for beneficiaries in Oregon, but it has been administratively cumbersome.

By contrast, Minnesota Senior Health Options (MSHO) is demonstrating an approach to contracting in which HCFA is holding the State accountable for both Medicaid and Medicare services, and the State is executing agreements with contractors that cover both Medicaid and Medicare services. Essentially, the State acts as HCFA's agent for Medicare, and is empowered to unify certain processes with approval from HCFA. Thus, MSHO members have one membership card, receive one packet of member information, and are enrolled into a single product on one date.

Integration can also occur without unified contracting, particularly if the contractor is committed to it through its mission. PACE sites, for example, have separate agreements with HCFA and states but are organizationally committed to achieving integrated care regardless of what their contracts may require. PACE sites are also unique in having had distinct status as participants in a national integration demonstration led by HCFA, in which a key goal of the experiment has been integration of care.

Enrollment

The enrollment process also differs significantly among existing and planned programs. One approach is to have separate enrollment mechanisms for Medicaid and Medicare, but to coordinate them to the point where they appear as one to the dually eligible beneficiary. In cooperation with the regional HCFA office and Medicare HMOs in the State, Oregon has attempted to create such a joint enrollment process for dually eligible beneficiaries wishing to enroll in Medicare HMOs. The parties in Oregon have achieved considerable success, despite formidable technical obstacles. They have developed a joint enrollment process for dually eligible beneficiaries that avoids enrollment in two separate MCOs for Medicaid and Medicare and does not require the beneficiary to go through two separate processes. Yet, they have not yet been able to establish a uniform enrollment date. OHP enrollment typically occurs sooner, with Medicare HMO enrollment following as much as two months later. The State determines the date of OHP enrollment, and HCFA determines the date of Medicare HMO enrollment. During the transition period, beneficiaries are in Medicaid managed care but Medicare fee-for-service. While this transition period does not appear to have been a problem for beneficiaries, it has resulted in significant administrative burdens for the MCOs and their providers. For example, depending on how an MCO pays its providers, it must determine with the providers who is responsible for billing Medicare during the fee-for-service period.

The other approach to enrollment, developed by MSHO, is to completely collapse the two enrollment systems into one, administered by the state in partnership with HCFA, the counties and the MCOs themselves. Enrollment forms may be completed at county offices or by MCOs, who submit the information to the State. The State completes the Medicaid portion of the enrollment to trigger a State Medicaid capitation, and also verifies Medicare information via on-line access to HCFA's Beneficiary Enrollment Retrieval system (BERT). The State identifies inconsistencies between the Medicaid and Medicare files, and makes edits in accordance with a protocol negotiated with HCFA. Applications processed up to 6 working days before the end of the month result in an enrollment date of the first day of the following month. The State sends electronic notice of enrollment to the plan and, through the Social Security Administration, to HCFA. HCFA recognizes the enrollment date established by the State and begins capitated Medicare payments as of that date. New members receive one set of program materials. Though only in use for a since early 1997, the system appears to be working smoothly to date.

Data Reporting

All of the states listed on Table 5 have or have requested §1115 Medicaid waivers and, therefore, require submission of encounter-level Medicaid data. In an integrated program, however, Medicaid tells only part of the story. In Arizona, where attempts are made to coordinate Medicaid and Medicare services, data reporting is split between the State and HCFA or its agents. For dually eligible beneficiaries receiving Medicare

services on a fee-for-service basis, HCFA agents receive Medicare claims data and process them for purposes of making payment. For those enrolled in Medicare HMOs, the HMOs will be reporting HEDIS 3.0 measures to HCFA beginning in 1998, but HCFA has not yet required submission of encounter data from Medicare HMOs. Neither HCFA nor the State has a complete data set that allows comprehensive analysis of service utilization across funding sources.

By contrast, PACE sites report all encounters without distinction of funding source to HCFA through DataPACE, the data collection and reporting system developed for the program. The data set is comprehensive and is used as part of HCFA's ongoing evaluation of PACE.

Similarly, Minnesota and Colorado will collect encounter-level data, without regard to funding source, from its contractors. They will be able to analyze the data itself for quality and other purposes, and will also share the data set with HCFA for evaluation and other purposes.

It is unclear how unified Medicaid/Medicare reporting will work in a program like MaineNET, in which Medicaid services will be capitated and Medicare services will be fee-for-service. Currently, Maine and the other New England states have obtained Medicare claims for past years and are linking those claims to Medicaid files at the beneficiary level for the purpose of program planning. It is unclear whether it will be possible for the State to obtain live access to Medicare claims as they are filed with HCFA's agent, to be used for program monitoring and improvement.

Table 5. Program Administration Approaches in Selected Programs

	Contract Admin.		Enrollment Determin.		Data Reporting	
	Medicaid	Medicare	Medicaid	Medicare	Medicaid	Medicare
Arizona Long Term Care System	State	HCFA, when applicable	State	HCFA, when applicable	Encounter level, to State	Claims or HEDIS 3.0, to HCFA ¹
Colorado Integrated Care and Financing Project	State	HCFA	State	HCFA	Encounter level, to State (one set)	Encounter level, to State (one set)
MaineNET (Waiver approval pending)	State	State, (same contract) when applicable	State	State, when applicable	Encounter level, to State	To be decided
Minnesota Senior Health Options	State	State (same contract)	State	State (single process)	Encounter level, to State (one set)	Encounter level, to State (one set)
Oregon Health Plan	State	HCFA, when applicable	State	HCFA, when applicable	Encounter level, to State	Claims or HEDIS 3.0, to HCFA ¹
PACE	State	HCFA	State	HCFA	Encounter level, to HCFA (one set)	Encounter level, to HCFA (one set)
Texas Star+Plus	State	HCFA, when applicable	State	HCFA when applicable	Encounter level, to State	Encounter level, to State

¹The HEDIS 3.0 requirement is being phased in. Medicare HMOs must agree to begin submitting it to HCFA in 1998.

C-5: Quality Management and Accountability

In this section, we consider approaches used by states to integrate their quality management activities across payment arrangements and settings of care. The design of managed care programs for the dually eligible beneficiary extends beyond the typical acute model of care into long term care and social support services. This expansion of services and settings of care challenges the capacity of a single managed care organization to effectively direct and be held accountable for the quality of care provided to beneficiaries.

Traditionally, quality assurance activities have occurred within individual “silos” of care -- nursing facilities, home health agencies, community-based providers, mental health centers, and hospitals. Federal and state mandates and private accrediting practices have fostered the development of segregated approaches to quality assurance and improvement and must be reconciled when attempting to overlay systematic approaches to quality across a broad spectrum of service providers. States and managed care programs have accommodated these challenges to integration in different ways.

Quality Management Philosophy

The Minnesota Senior Health Options program (MSHO) and the proposed Colorado Integrated Care and Financing Project (CICFP) concede to the inevitable autonomy of service providers to oversee quality of care but place accountability within the managed care plan for beneficiary outcome. This model requires a negotiated process between the managed care plan and each of its subcontractors and allows a great deal of flexibility in how service providers approach quality management. Key to this model, however, is the development of outcome measures against which the plan and its service providers are held accountable. In the case of MSHO, these measures focus on specific clinical conditions and the ability of plans to “grease” transitions between care settings. Colorado is developing a series of process measures relating to enrollment/disenrollment and the calculation of repeat hospitalizations and emergency room use which may be indicative of poor outpatient care.

Maine, and to a lesser extent Arizona, envision a system which places greater authority within the MCO to influence quality management activities at the provider level. Through the development and dissemination of practice guidelines, shared learning, peer review activities, and other prescribed quality improvement tools, these programs hope to impact traditional practice patterns. At this point, it is unclear whether there will be sufficient leverage, resources and credibility to redirect provider behaviors and to create new models of care across service settings.

PACE and other vertically integrated managed care systems have unique advantages to span the silos of care and affect system-wide changes to quality management and improvement activities. Heavy reliance is placed on population-based needs assessments which permit the system to set priorities for quality improvement and outcomes that are not measured at a single site of care. The system defines its expectations for care based

on rigorous evidence regarding successful interventions. Standards of practice are promulgated which assist practitioners and members in making effective decisions regarding care.

These examples illustrate that, although there is agreement that the managed care organization is accountable for beneficiary outcomes, there is significant disparity in how much control is exercised by the managed care organization over the structure and process of care at the point of service.

The following four areas address aspects of quality management that are perceived to be most prone to fragmentation:

- Participation in the quality management process;
- Internal quality improvement program standards;
- Performance measurements; and
- Quality oversight.

As will become evident in our review, disparate federal and state policy and provider “turf” issues often perpetuate this fragmentation and reduce opportunities for full integration. But states are overcoming historical barriers both through collaborative and regulatory approaches to change.

Participation in the Quality Management Process

Integration can be measured by the degree to which diverse individual and institutional providers, and consumers have been effectively consulted in the quality management activities of the managed care program. Do they participate on Quality Committees or assist in the design of focused studies and surveys? What mechanisms are used to engage them in the process of continuous quality improvement? How do they become knowledgeable about best practices relevant to older persons and persons with disabilities?

Integrating key players into quality management activities can occur at the state and plan levels. In Maine, the state has assumed a leadership role in facilitating exchanges among providers and consumers in the planning phases of MaineNET through the activities of a Quality Work Group. In addition to the Work Group’s ongoing interest in monitoring the implementation of the demonstration, a multi-disciplinary Clinical Advisory Panel will be formed to advise MaineNET in the review and interpretation of service data, and in the identification of intervention strategies where broad variations in practice patterns and/or poor outcomes exist. The Clinical Advisory Panel will include clinical opinion leaders in the area of geriatrics and disabilities.

The National Chronic Care Consortium Resource Center is working under a contractual agreement with Minnesota Senior Health Options (MSHO) to provide technical assistance, best practice tools and resources to health plans participating in the project. As part of this initiative, a Clinical Integration Working Group will be formed including

representation from health plan contractors, participating provider systems, consumers and other key organizations. Colorado has cultivated partnerships between the managed care plan and traditional long term care providers. State-sponsored training programs have enabled providers from multiple perspectives to come together to discuss approaches to management of clinical conditions prevalent among the target population. Arizona convenes quarterly meetings of the Medical Directors, Quality Management staff and Case Managers from the managed care plans with which they contract. These meetings provide opportunities to coordinate activities among the managed care plans and identify the emergence of clinical issues affecting the care of members.

How well providers and consumers are integrated into quality management activities at the plan level is less clear. Formal requirements for such integration are frequently specified in contracting or other accrediting standards. Draft Accreditation Standards for PACE require the active participation from all areas of the PACE program, including members and caregivers, in the design and implementation of the quality improvement program. This involvement is further augmented by requirements that the policy making or governing body be reflective of the membership and composed of individuals with relevant knowledge and experience. PACE is planning to test the draft standards on a pilot basis before permanently promulgating their voluntary use among PACE sites.

MaineNET's proposed contracting standards specify that there be a Quality Improvement Committee or other structure which includes members, the Medical Director, and other medical and health professionals who are representative of the scope of services delivered under the program. In conducting their quality improvement activities, MaineNET requires Integrated Service Networks (ISNs) to show evidence as to how the organization includes input from members, family members, informal care givers and providers in the quality management process.

Arizona, Colorado and Minnesota take a far less intrusive approach to dictating how the managed care plan chooses to involve providers in their quality management activities. These states ascribe to the philosophy that there is no single solution to developing a collaborative quality management program and that each plan and network must cultivate arrangements responsive to their situation. Both Colorado and Oregon do, however, encourage the involvement of consumers in the process and Oregon further stipulates that the quality management functions must have consultation from individuals with knowledge of all populations served under the program.

Internal Quality Improvement Program Standards

As the movement to managed care has accelerated, so too has the proliferation of quality standards and review processes. Most of these standards affect how plans must organize their quality management activities or dictate the type and manner of data collection and analysis which must be conducted. In addition to regulatory standards imposed by Medicare and Medicaid, integrated service delivery systems are also subject to licensure standards, private accreditation standards, state insurance requirements and other regulatory and private review processes. Some of these standards may be the same while

others may conflict in both minor and major ways . Working to comply with the standards is a costly proposition and may actually divert effort away from improvement in the quality of care.

As states develop integrated programs for the dually eligible beneficiary, interest in streamlining Medicaid and Medicare requirements intensifies. HCFA has recently launched an initiative to design a quality improvement system for use by HCFA and optionally by states in their oversight of managed care plans contracting with Medicare and Medicaid. The goal of the QISMC initiative (Quality Improvement System for Managed Care) is to propose a consistent set of standards for Medicare and Medicaid managed care. This effort to “standardize the standards” may relieve many of the redundant demands placed on managed care plans as conditions of Medicare and Medicaid participation but will not completely address similar discrepancies between public and private quality standards.

States have limited authority to tackle the fragmentation of external standards. They can, however, promote greater standardization of requirements imposed by state agencies with oversight responsibilities for managed care, such as Medicaid, licensure and insurance. Alternately, a state may “deem” another entity’s standards or review process as replacement for its own, thus reducing the number of separate requirements a plan must satisfy.

MSHO provides an early example of both the challenges and opportunities in working collaboratively with HCFA to reduce redundant requirements while protecting the unique interests of the Medicaid and Medicare programs. Minnesota has carefully documented how its Medicaid standards equal or exceed those of Medicare in an effort to simplify compliance review for contracting. For example, there will be a single point of entry and process for all complaints up through and including the Medicaid fair hearing. Through a negotiated process with HCFA, determinations will be made as to whether unresolved complaints at that point are primarily Medicaid or Medicare and thus subject to different administrative reviews.

MaineNET has made a conscious effort in the design of its program standards to streamline them, whenever feasible, with those imposed by state licensure and private accrediting bodies. Implicit in these efforts has been the goal to coordinate review processes wherever another entity’s standards and processes are found to be essentially equivalent with that of the MaineNET program. Variations in standards tend to focus on standards related to access, beneficiary participation, and network capacity - areas where private sector interests are usually less stringent than those required by plans serving vulnerable public members. Standards for the Arizona Long Term Care System (ALTCS) and Texas Star+Plus are coordinated with those of the State’s managed care program for acute care but are not necessarily compatible with Medicare. Efforts to streamline Medicaid and Medicare standards have not been priority in Arizona since the State has no direct role in how Medicare services are provided to its dually eligible beneficiaries.

Because of the very real differences in populations being served, integrating standards of public and private review bodies into a single set of requirements is not plausible. There are many advantages, however, to determining whether differences among agencies are material to the focus of each agency or if, through reasonable modification, they can be made equivalent. As agencies reach agreement on a “core” set of standards, it then becomes possible to integrate the results of another entity’s compliance review process into the monitoring activity. Furthermore, it allows each oversight agency to focus its standards and review processes on those aspects and operational areas most pertinent to its unique interests (e.g., focused review by Medicare and Medicaid on access and network capacity).

Performance Measurement

Performance measures are often the hub driving the focus of quality improvement activity. The questions raised under an integrated model of care are whether measures reflect a single standard or outcome of care that can be assessed across providers and payors, and whether the measures are holistic in accounting for both quality of care and quality of life.

Major strides have been made to develop common sets of measures for use by public and private purchasers. Measures developed under HEDIS 3.0, The Foundation for Accountability (Facct), and Consumer Assessments of Health Plans Study (CAHPS) all aim to standardize the collection and reporting of data across payor arrangements. States have borrowed heavily from these sources and, in their design or adoption of measures for integrated delivery programs, have developed standards which cross care settings and which account for the full diversity of care needs and outcomes among the target populations.

MSHO is selecting clinical and structural measures crossing settings of care. Initial focus will be on diabetes, urinary incontinence and care transitions. Of particular interest to Minnesota will be data collected on a sample of community-based nursing facility-eligible members which capture the programmatic and clinical factors impeding and enhancing care transitions.

Maine is participating in a regional process with the New England Consortium to develop a common set of performance measures for use by all New England states in monitoring quality in priority areas. The Consortium is looking to augment HEDIS 3.0 and address physical and mental disabilities and quality of life issues. In addition, MaineNET-specific measures will be proposed which take advantage of the comprehensive database on the State’s institutional and community-based long term care beneficiaries, including assessment data on functional status, cognitive impairments, and social support systems across settings and over time.

Colorado has been working with the National Committee for Quality Assurance (NCQA) to develop a series of measures focusing on system responsiveness and preventive measures which incorporate community-based and institutional care. Arizona takes a

population-based approach to its measurement process and plans to phase-in measures pertaining to the elderly and physical disabilities, developmental disabilities and behavioral health over time. To the extent possible, common measures will be developed for institutional and community-based long term care members. Similarly, PACE is engaging in a process with HCFA's consultants from the Center for Health Policy Research at the University of Colorado to design an Outcome-Based Continuous Quality Improvement (OBCQI) program for the PACE sites. Outcome indicators and interventions will be developed which address how "downstream" providers affect functional and medical conditions of members.

The Self-Assessment for Systems Integration (SASI) Tool developed by the National Chronic Care Consortium examines how well a health care network integrates care across a full continuum of settings and services. Minnesota has made an initial attempt to derive performance measures from this tool for use in the State's readiness review process.

Quality Oversight

Plans serving Medicaid and Medicare beneficiaries are subject to multiple reviews to evaluate quality of care. All plans are subject to review by state licensing or insurance agencies and, in addition, may optionally seek private accreditation review. The State Medicaid agency reviews for compliance with Medicaid contracting requirements and HCFA Regional Office determines compliance with Medicare conditions of participation. Plans contracting with Medicaid and Medicare are further subject to a federally mandated annual, external quality review. Medicare external quality reviews must be conducted by a peer review organization (PRO) whereas Medicaid reviews may be conducted by a PRO, a PRO-like entity or a private accrediting body. To further complicate the situation, the State contracts for the external quality review required under Medicaid whereas the plan directly contracts with the PRO for the Medicare external review.

This labyrinth of overlapping review responsibilities and processes requires extensive resources with potentially limited quality improvement benefit. As each agency chases after documentation to determine compliance with its requirements, the managed care plan is diverted from its primary focus on improving quality. Attempts to "standardize the standards", as previously discussed, offers an opportunity for agencies to coordinate if not consolidate the number of compliance reviews. But statutory and "turf" considerations impede progress in this regard.

Two models are emerging for integrating quality oversight activities. On the one hand, states are working internally to improve coordination among sister agencies with oversight responsibilities. Minnesota has a cooperative agreement between the Medicaid and licensing agencies specifying their unique roles and willingness to share review findings with each other. Maine has identified three areas for coordinating reviews between Medicaid and insurance: quality oversight, complaints and grievances and financial solvency.

Less dramatic convergence of Medicaid and Medicare reviews is also underway. Arizona, Colorado, Maine, and Minnesota all use or plan to use the same PRO that contracts for the Medicare external review to conduct the mandated Medicaid external quality review. In Arizona, separate reviews are conducted although by the same PRO. The other States “piggy-back” onto the Medicare scope of work hoping to facilitate shared focused studies in areas of mutual interest and to augment the scope in areas of special relevance to Medicaid. For example, a Medicare study on diabetes could include separate samples and analyses for the dually-eligible membership. Similarly, under contract with the state, the PRO may conduct satisfaction surveys comparing the experience with care among Medicaid only, Medicare only and the dually eligible beneficiary. While constrained by the statutory restrictions regarding two distinct contracts, states and their PROs are creatively developing compatible work plans.

State Medicaid agency staff and HCFA Regional Office staff both conduct onsite reviews to determine plan compliance with contracting standards. In Colorado and Minnesota, protocols for joint reviews with HCFA are being developed to facilitate the sharing of information and reduce redundant activities. Efforts to examine duplication of review areas have been undertaken by HCFA through a series of interviews with State Medicaid agencies, National Committee for Quality Assurance (NCQA) and national HMOs. Although no dramatic shifts in authority are anticipated, joint reviews are expected to continue and serve as laboratories for better understanding how HCFA and states can coordinate their roles and, in the process, promote the quality of care.

States, such as Maine and Oregon, are considering how to make use of findings from private accrediting reviews to enhance or focus State compliance review. These findings are typically proprietary and thus States must acquire the appropriate consents to ensure that the level of detail required to substitute one review for another is available.

Table 6 summarizes the discussion in this section.

Table 6. Quality Management Approaches in Selected Programs

	QM Philosophy	Participation in QM	Internal QAP Program Standards	Performance Measures	Quality Oversight
AZ Long Term Care System	Limited prescriptions in how managed care plans involve providers in QM activities.	<u>State</u> : quarterly meetings with plan Medical Directors, Quality Managers and Care Managers <u>MCO</u> : no specific requirements for provider participation in the QM process.	Standards coordinated with State's managed care system for acute care; limited coordination with Medicare.	Development of process/ outcome measures which cross settings of care.	Separate reviews conducted by same PRO for external quality review. Onsite state reviews conducted independent of other agencies and managed care programs.
Colorado Integrated Care and Financing	Flexibility in structure/process of QM at provider level; MCO/State focus on care outcomes	<u>State</u> : fosters partnership between MCO and traditional LTC providers <u>MCO</u> : no state-prescribed participation in QM process with exception of consumers.	Contracting standards under development; foresee separate standards not necessarily coordinated with state/federal standards.	Development of structure/ process measures which cross settings of care to augment HEDIS 3.0.	Joint onsite reviews with HCFA Regional Office; combined studies through use of same PRO to conduct mandated external quality reviews under M'care and M'caid.
Maine-NET	Prescribed model of QM with MCO and State playing key roles in directing & monitoring structure, process & outcome of care	<u>State</u> : active involvement of Quality Committee and use of Clinical Advisory Panel in monitoring service appropriateness. <u>MCO</u> : State requires MCO QM structure to have broad clinical, member and care giver representation.	Goal to increase consistency among standards of state oversight agencies and private accrediting bodies.	Development of functional status and preventable hospitalization measures to augment select HEDIS 3.0.	Proposing to use same PRO to conduct mandated external quality reviews for M'care and M'caid; shared reviews with state licensure and HCFA Regional Office.

	QM Philosophy	Participation in QM	Internal QAP Program Standards	Performance Measures	Quality Oversight
MN Senior Health Options	QM is a negotiated process between MCO and service provider; MCO focus on “transitions” between services and settings.	<u>State</u> : Ad-hoc involvement on issue-specific basis. <u>MCO</u> : inclusion of service providers and settings in QM process	Plans subject to blended set of M’care/M’caid standards where feasible; efforts to increase consistency among standards of state oversight agencies	Development of clinical and structural measures which cross settings of care in area of diabetes, incontinence and care transitions.	HCFA Central and Regional office oversight of state conducted under “Merged Review Guide” ; external quality reviews of plans conducted by same PRO for M’care/M’caid
OR Health Plan	Overall structure of quality improvement mandated by rules; some processes prescribed. Emphasis on outcome.	<u>State</u> : Rulemaking an iterative process engaging consumers and providers alike. <u>Plan</u> : QI committee includes representative providers and professionals.	Standards based on NCQA and QARI guidelines as well as existing state ambulatory standards, where applicable.	Builds on financial measures developed by Nat’l Assoc. of Insurance Commiss. (NAIC) and HEDIS	Different PRO for Medicaid and Medicare mandated reviews. State conducts independent evaluation visits.
PACE *	Prescribed framework for QM at PACE provider level; focus on process and outcome of care.	<u>State</u> : not applicable <u>PACE Site</u> : QM process includes active participation from all areas of PACE program, including participants and caregivers.	Separate standards not necessarily coordinated with state/federal standards.	Development of outcome measures now underway focusing on functional and medical conditions	Independent review for PACE accreditation unrelated to M’caid and M’care external quality reviews.
Texas Star+Plus	Overall structure of QM follows QARI guidelines; flexibility built into system allowing for plan variations.	<u>State</u> : state-sponsored advisory committee includes broad range of input. <u>Plan</u> : QI Committee includes older persons and persons with disabilities and community providers.	Standards compatible with those of TANF program where applicable; additional standards modeled after Contracting Specifications for dually eligible.**	State uses subset of HEDIS 3.0; considering the application of QI indicators for nursing facilities developed under the State’s casemix demonstration project to track medical and functional outcomes of NF members.	State currently soliciting proposals for M’caid external review from PROs, PRO-like entities and accrediting bodies; no final decision as to whether M’care PRO will be selected.

* Responses reflect standards included in draft PACE accreditation standards. These standards are subject to future revision.

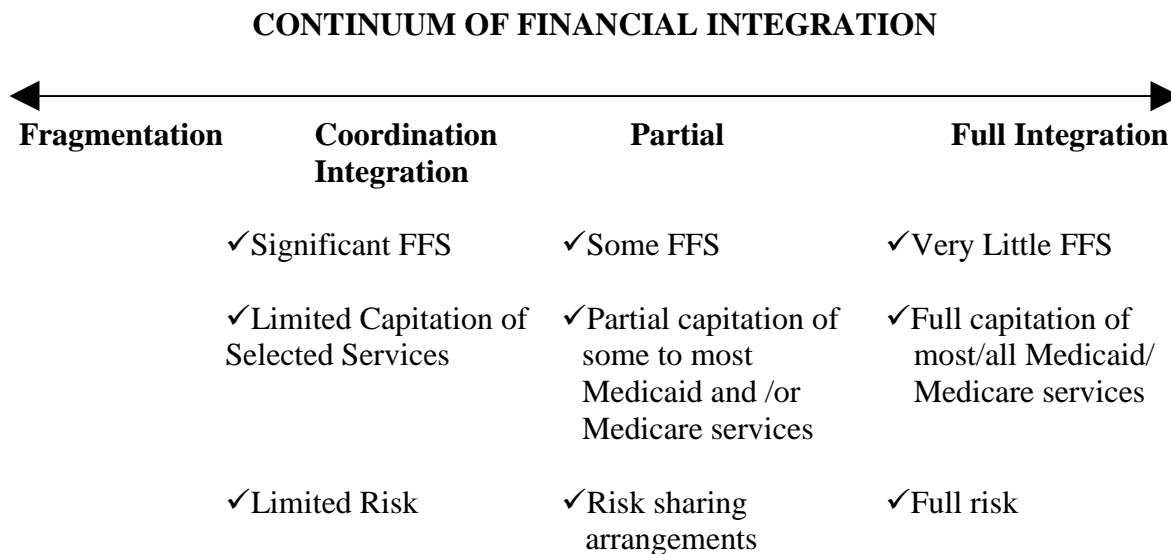
** HCFA’s Medicaid Managed Care Technical Advisory Group (with assistance from The Center for Vulnerable Populations (Collaboration of The National Academy for State Health Policy and The Institute for Health Policy - Brandeis University), A Framework for the Development of Managed Care Contracting Specifications for Dually Eligible Adults, November 1996.

C-6: Financing and Payment

A state's programmatic goals will define the parameters of the system's financing and rate structure. Often the goals will be conflicting or have multiple implementation schedules. The goals will influence, for example, what services will remain fee-for-service, the scope and structure of a capitation rate, how much risk the state wants to pass on or share, and whether the program will be voluntary or mandatory. As indicated previously, the most commonly articulated goals are to eliminate fragmented service delivery, to contain costs and to develop a coordinated service delivery system. Other goals can include: to improve the overall quality of services provided, to promote the development of community based managed care infrastructures (often most important in rural states), to provide flexibility in benefit design and to maximize consumer choice. How these goals are prioritized and the time horizon over which a state wants to accomplish the goals will ultimately determine how integrated the financing of the Medicare and Medicaid programs will be.

Continuum of Financial Integration

Financial integration can be conceived of along the integration continuum and may include combinations of Medicaid and Medicare capitation and fee for service payments. While full integration is often viewed as the ultimate goal, many other models are operating and provide successful examples of programs that are serving dually eligible beneficiaries. The following outlines a framework for the continuum of financial integration:



Coordination

The first step along a continuum of financial integration often begins with the development of programs where Medicaid and/or Medicare services are coordinated and/or authorized by a single entity or provider but where significant amounts of Medicaid or Medicare dollars remain fee-for-service. For example, a primary care physician may receive a case management fee to authorize certain services or a group of physicians or a provider may be at risk for a limited number of services. Often such approaches are used during a start-up phase to allow fledgling risk-based organizations to put together their clinical team, build their administrative capacity and form their delivery system networks.

One of the most basic examples of coordinated care programs are the Medicaid primary care case management (PCCM) systems that many states have implemented for their AFDC populations. These programs usually pay a primary care provider a case management fee for authorizing and coordinating Medicaid services. Existing Medicaid PCCM programs, however, do not typically apply to dually eligible beneficiaries or to Medicare services.

Oregon is one state that has a primary care case management option for dually eligible beneficiaries and others. This option is offered as a choice in areas that do not have two capitated plans or on a case by case basis for people with exceptional care needs. Approximately one third of the dual eligible beneficiaries in Oregon are using the PCCM option. As an add-on to Oregon's 1115 Waiver evaluation, ASPE is also sponsoring a comparative analysis of the PCCM option versus HMOs.

The Pre-PACE sites represent examples of programs that started by partially capitating some but not all Medicaid services (e.g. nursing facility, physician, and all optional state plan services) while Medicare services remained fee-for-service. This approach provided the PACE sites with the time necessary to develop their clinical management and care coordination systems for integrating acute and long term care services. It also phased in the amount of risk that the organizations had to assume in the early years of the programs. This incremental approach, while providing a start-up period, does have the potential for cost shifting to the fee-for-service sector.

The MaineNET program proposes to include a Medicare Primary Care Case Management component that will be used to integrate the physician services into a Medicaid managed care program. Depending on the market response to the MaineNET program, the Medicare PCCM will be offered as part of a plan's managed care program or implemented as part of Maine's existing Medicaid primary case management program. In the instance where the PCCM program is included as part of the managed care program, the managed care plan will receive a case management fee to cover the services of the physician in coordinating and authorizing Medicare services. If the Medicare PCCM program is offered as part of the Medicaid PCCM program, the state will administer the program and the PCP will be paid a case management fee directly from the state.

Partial Integration

As a program or health plan begins to assume greater amounts of risk for a significant number of Medicaid or Medicare services, the amount and degree of financial integration increases. The importance of having a strong case management and care coordination function also increases since the organization is at financial risk for a greater number of services. While some services still remain fee-for-service, mechanisms to coordinate the managed care services and the fee-for-service benefits are developed.

In Arizona, the ALTCS program covers the full package of Medicaid long term care services and plans are at full risk for those services. Medicare services may be provided through the ALTCS plan or through a different Medicare HMO. Medicare services may also be fee-for-service. The ALTCS contractors are responsible for the copayment and deductible amounts associated with Medicare services that are delivered through their networks. Thus it is in their interest to have a strong care management function and mechanisms to coordinate with the Medicare system.

In Oregon, Medicaid medical and acute services are capitated while long term care services remain in the fee-for-service system. If a dually eligible beneficiary chooses to enroll in an OHP plan that is also a Medicare TEFRA plan, the beneficiary must enroll in both the Medicaid and Medicare managed care program. If the OHP plan is not a Medicare TEFRA plan, the beneficiary may continue to receive Medicare services on a fee-for-service basis. If a beneficiary enrolls in a Medicare plan that is not an OHP plan, then Medicaid services remain fee for service.

Moving along the integration continuum, Minnesota Senior Health Options and the Colorado Integrated Care and Financing Project provide examples of programs that have or propose to integrate the financing and delivery of virtually all Medicaid and Medicare services. Much of the development work for these programs focuses not only on the financing and capitation arrangements but on the development of plan capacity to provide and coordinate long term care services. In Colorado, the state has taken an active role in defining and brokering the relationship between Rocky Mountain HMO (that has traditionally managed acute and medical services) and the county based agency responsible for coordinating long term care services. Minnesota, on the other hand, has defined the care coordination and eligibility determination functions that it wants the plan to perform and given the plans the discretion to either perform them internally or contract for those services.

Full Integration

This is often viewed as the ultimate goal in the development of managed care plans for the dually eligible. Theoretically, at least, a fully integrated system would include a single capitation rate for all Medicaid and Medicare services and cost savings and losses

would be shared by both programs. Massachusetts recently proposed a unique approach in its 1115 Waiver application for Dual Eligible Seniors. In their proposal, Medicare and Medicaid payments to the Senior Care Organizations would continue to be made separately. Medicare payments would be based on a modified AAPCC method and Medicaid payments would be set equal to the difference between the total capitation payment and the Medicare payment. This approach, while keeping the funding streams separate, has the potential to align the incentives of the Medicaid and Medicare programs to reduce cost shifting and promote cost savings.

A number of factors have contributed to the slow development of fully integrated managed care financing approaches. First, the development of integrated Medicaid and Medicare financing mechanisms require partnerships between states, the federal government and managed care plans. While the Medicare HMO market has grown considerably in the last few years, state initiatives to capitate the Medicaid component of services for the dually eligible are still in the developmental stages. Furthermore, the number of plans that can or are willing to bear the amount of risk associated with a Medicare and Medicaid capitation payment is limited. The variability of the Medicare AAPCC by region has also had an impact on the market penetration of Medicare HMOs in different areas of the country.

From a financing perspective, the development of a common methodology for capitating Medicaid and Medicare services has been limited by the categorical nature of the two programs and until recently the segmentation of Medicaid data and Medicare data. Advances in technology and the availability of linked Medicaid and Medicare data provide new opportunities to develop common capitation methodologies and risk adjustment methodologies that would span the Medicare and Medicaid systems. This might still result in separate capitation payments from Medicaid and Medicaid but such payments could be computed using a common rate structure, risk adjustment methods, and financial incentives.

Development of Capitation Rates

The development of capitation rates for dually eligible older people and people with disabilities is still in its infancy. Since managed care programs for the dually eligible rely on two funding mechanisms (Medicaid and Medicare), it is helpful to understand and address issues related to the development of Medicaid capitation rates and Medicare capitation rates.

Standard Medicaid practice is to pay managed care plans a percentage of the fee-for-service average per capita costs adjusted for factors such as age, sex, gender, region, eligibility status (i.e. Medicaid-only versus with Medicare Part A or Part B) and disability status (aged versus disabled). Medicare premium payments to risk based HMOs are based on 95 percent of the adjusted average per capita cost (AAPCC) of Medicare beneficiaries participating in the traditional fee-for-service Medicare program. The AAPCC is also adjusted for age, sex, welfare status, institutional status and geographic region. States that have or are developing programs to serve the dual eligible populations have also become

increasingly interested in refining the more traditional capitation rate approaches (for both Medicaid and Medicare) to reflect the chronic care needs of the target populations and to address the potential for risk selection bias. A number of states discussed in this paper, for example, have requested and received approval from HCFA to use a modified AAPCC methodology for Medicare services. In addition, HCFA and the RWJ foundation have funded research and demonstration projects to develop and test risk adjusted capitation methods.³

The development of Medicaid capitation rates typically begins with equivalent fee-for-service costs for the services that are to be managed by the program contractors and for the target populations of interest. State policy makers need to guide the development of the rate structure to assure that the financing system remains aligned with the state's programmatic goals. Actuarial consultants will be able to test and model the rate structures and assure that appropriate actuarial principles are followed. It is, therefore, critically important that the policy objectives are clearly articulated, that administrative systems are in place that can support the capitation rate structure and that information systems are adequate to monitor the adequacy of the rates over time. If states are interested in developing more sophisticated rate structures later on, it is important to collect the necessary health status measures that might be used in future rate setting.

Some of the key questions that states must address in developing their capitation rates are:

- *How should the rate cells be structured and what costs will be included in the capitation rate cells?*
- *What kind of age, sex, or risk adjustments should there be?*
- *What kinds of risk sharing (e.g. risk corridors, re-insurance) should there be and for how long?*
- *Are the rates designed in a way that will be budget neutral?*
- *What mechanisms can be used to promote the integration of Medicaid and Medicare financing and minimize programmatic cost shifting?*

How should the rate cells be structured and what costs are included in the capitation rate?

One of the major advantages of capitation financing is that it provides program contractors with a great deal of flexibility in developing plans of care and services that meet the needs of individual enrollees. Unlike the fee-for-service system where services are often defined by the categorical nature of the Medicaid program, in a managed care

³ "Managed Care: Advances in Financing," *Health Care Financing Review*, Volume 17, Number 3, Spring 1996.

environment the plan must work within a global capitation rate for each individual. Many states that have developed rates for the dually eligible have done so using very aggregate rate categories thereby providing maximum flexibility to program contractors and also spreading the potential risk over a large population base.

The inclusion of long term care services in capitation rates creates new challenges and opportunities for states. It is a challenge in that NF level services and NF residents have not traditionally been served in managed care programs and represent considerable risk for program contractors. It is an opportunity in that the development of new capitation rate structures that include long term care can provide strong incentives to move away from the historical institutional bias of the Medicaid program and promote the use and development of home and community based options.

Table 7 provides an overview of the rate structure used by a number of states. The costs included in the rate cells represent average per capita costs usually reduced by a factor for managed care savings.

Table 7. Approach to Medicare and Medicaid Capitation in Selected Programs

	Medicaid Capitation	Medicare Capitation
Arizona Long Term Care System	Includes weighted average of NF and Home and Community Based LTC costs. Medical and acute costs, behavioral health and case management costs also included.	Medicare TEFRA rates
Colorado Integrated Care and Financing Project	LTC Qualified: Includes NF and Home and Community Based Waiver costs. Basic LTC: Includes home care allowance and adult foster care costs for those who are not NF qualified. Medical/acute care rate based on existing managed care program.	Actual Medicare cost based rates with the adjustments for elderly who are NF eligible in the community (PACE Adjustor); and new adjustments for nonelderly who are NF eligible in the community; and NF residents and others.
MaineNET	NF Eligible: Includes weighted proportion of NF and home and community waiver costs. NF costs will be case mix adjusted. Community Eligible: Weighted average proportion of residential care and community based service costs. Residential care costs will be case mix adjusted. Medical/acute care costs included.	Medicare Primary Care Case Management Fee
Minnesota Senior Health Options	NH residents upon enrollment: Medical/acute costs (PMAP rate) but NF per diem remains fee-for-service. NH Certifiable Conversions: Medical/acute costs and 95% of 2 X the average monthly Elderly Waiver payment. Community Nursing Home Certifiable: Medical/acute costs and 95% of the average monthly Elderly Waiver payment and a NF Add-on. Community Non-NHC: Medical/acute and NF add-on.	Medicare TEFRA rates plus 2.39 factor (PACE risk adjustor) for NF conversions and NF certifiable rates.
Oregon Health Plan	Includes all medical and acute costs for elders and disabled. LTC not included in the program	Medicare TEFRA rates
PACE	State-specific Medicaid rates based on historical use of NF/community services	Medicare TEFRA rate plus 2.39 risk adjustor
Texas Star+Plus	Separate rate cells for Medicaid only and dually eligible: Community based Waiver clients Other Community Clients New Nursing Facility clients Voluntary Nursing facility clients Medicare copay and deductibles paid fee for service for those in non Medicare risk plan. For dual eligibles in Medicare risk plans, Medicaid excludes copay and deductible.	Medicare TEFRA rates

Medicaid Capitation Rates

The development of programs to serve the NF eligible populations and to include LTC costs has resulted in the creation of new rate cells that are not typical of the AFDC population. In Arizona, the ALTCS program only applies to those who are NF certifiable and thus there is a single rate cell for the costs associated with providing services for this population. The use of the weighted average of NF and home and community based LTC costs provides strong incentives for program contractors to provide services in the community and to move away from a reliance on institutional level of care. When the program first began, HCFA placed a 5% cap on the number of HCBS slots available to the elderly or physically disabled enrolled in the program. Currently there is a 40% statewide cap although the state believes there should be no such cap.

A significant difference between Arizona and other states is that a single contractor serves all ALTCS enrollees in a county and all NF certified Medicaid beneficiaries must use the single contractor. From a rate setting perspective, this greatly reduces the consequences associated with adverse risk selection since all eligible participants in an area are enrolling in a single plan.

The Colorado Integrated Care and Financing Project, MaineNET and PACE also use or propose rate cells that apply to the NF eligible (or NF certifiable populations). In the Colorado program, the LTC qualified rate cell includes all NF and home and community based waiver costs. The costs in this cell represent the historical distribution of people served in NFs and people served in the community and the respective costs associated with those programs. While there is an implicit distribution built into the Colorado rate cell of NF and home and community based costs, the rate cell is not built around a targeted proportion of people to be served in NFs versus in the community. Nevertheless, the structure of the rate cell provides the same incentives as those in Arizona, i.e. to serve people in the least restrictive and less costly setting. Because the program in Colorado will be voluntary, the rate structure does not have the same level of risk selection protection inherent in the mandatory Arizona program.

The MaineNET rate cell for NF eligible enrollees, like Arizona's, will include blended NF and home and community based waiver costs that will be developed based on a combination of historical and expected proportions of people who may be served in the community versus in a NF. In the start-up years of MaineNET, it is expected that this proportion (the percent in the NF versus in the community) may need to be adjusted on a fairly frequent basis to account for differences in the enrollment distributions of program contractors. The costs associated with the NF level of care will be adjusted for the case mix of individuals who enroll in the program. Case mix will be determined using the NF RUG-III system and the MDS assessments that are completed in the nursing facility. It is proposed that the capitation rates will reflect the case mix of all enrollees in a managed care plan in the prior year. For the Community-eligible rate cell, the rates will be developed based on the expected proportion of people who are in residential care facilities and those who are in the community. Maine is also in the process of

developing a case mix system for residential care facilities that will be used in the development of the community-eligible rate cell.

The Medicaid capitation rate for PACE programs varies from state to state based on the comparison group used by a state and historical use patterns of those in NFs versus those in the community. In some states (California, New York, So. Carolina and Wisconsin) the state's average per capita expenditures for a comparable NF population is used. In other states (Mass., Colorado, Illinois) both institutional and community based populations have been used for comparison and rates developed based on average per capita costs of those served in both programs based on the numbers served in each.⁴

One of the major challenges for the PACE program and for states that are developing capitation rates is to determine the appropriate weighting between these two groups. While the weighting will be developed in part based on historical experience, it is also a function of the state's commitment to the expansion of community based alternatives and the supply of nursing home beds in a state.

Minnesota has taken a different approach from the other states and has developed four major rate categories: (1) Institutionalized (NF) residents, (2) NH certifiable conversions (3) Community NH certifiable, and (4) Community Non-NHC. *For residents who enroll while in a NF*, the Medicaid rate includes the medical/acute capitation rate (PMAP rate) for institutional residents. The NF costs remain fee-for-service. *The NH Certifiable conversion rate* is assigned after an enrollee has been institutionalized for 180 days and then moves to a community setting. The rate is then based on 95% of twice the average cost of the elderly waiver program and includes the Medicaid institutional PMAP rate. *The Community NH certifiable rate* includes 95% of the average monthly Elderly Waiver payment, the Medicaid non-institutional PMAP rate and a Medicaid NF add-on. The Health Plans are responsible for 180 days of NF care for any person who enrolls while in the community. *For Community Non-NHC recipients*, the rate includes the Medicaid non-institutional PMAP rate and a NF add-on.

The Minnesota approach limits the liability of program contractors for long term nursing facility stays while providing incentives for early discharge planning. By establishing the NF add-on, the plans are also at risk for those in the community who may need short term NF care. This provides an incentive to develop preventive approaches, prevent deterioration and reduce the NF admission rate. The Minnesota rate structure also differentiates between an institutional and non-institutional rate for medical and acute care services. This also provides incentives to manage and control hospital and acute care utilization.

In Texas, rate categories have been established for those who are Medicaid only and those who are dually eligible in the following groups: Clients receiving Community Based Alternatives in the Waiver program (CBA Waiver clients); Others in the community; New nursing facility clients and Voluntary nursing facility clients (those

⁴ Medicaid Rate Setting for PACE.

residing in the nursing facility prior to 2/1/98). Texas has also developed its rate structure to provide incentives to serve people in the community. Historically there had been a cap on the number of people who were NF eligible who could be served in the Waiver program. With the Star+Plus program, this cap would be removed. In addition, the NF rate cells have been adjusted to reflect a discounted NF rate and the CBA rates are structured to reflect approximately 85% of the NF level costs. For those in the community, the rates will include up to 120 days of care in a NF.

The medical and acute care Medicaid costs for the dually eligible will be paid fee-for-service. For those who are receiving Medicaid and Medicare managed care services through a single plan, the Medicare HMO will cover the copays and deductibles for medical and acute care services through their Medicare TEFRA rates.

Medicare Capitation

Managed care programs that have been developed to serve dually eligible beneficiaries have had to address not only how to design Medicaid capitation rates but how to design Medicare capitation rates. Medicare risk-based HMOs receive 95% of the average adjusted per capita cost AAPCC. The actual payment to the HMO is determined through a series of adjustments. Based on a national average Medicare per capita cost, the AAPCC is determined for each county, is calculated separately for Parts A and B, for elderly and disabled and for institutional status. In Arizona and Oregon, the Medicare HMOs receive the Medicare HMO rate for the dually eligible.

When the PACE program began, an adjustment to the AAPCC was developed to reflect the enrollment of the high risk NF eligible population. This factor (measured as a 2.39 adjustment) captured the higher Medicare costs associated with caring for the frail elderly in the community. In Minnesota, the program contractors for the MSHO program receive the Medicare AAPCC rate with an adjustment factor of 2.39 for NF conversions and NF certifiable rates. Colorado is proposing to use cost based Medicare capitation rates with separate adjustments for different populations. The Medicare rate for the NF eligible elderly population will include the 2.39 PACE adjustor. The NF eligible population under 65 will have a new adjustment factor that is being developed for this age group. The nursing facility residents and all others will also have a separate adjustment

The more recent availability of linked Medicaid and Medicare data should provide further opportunities to analyze the relationship between Medicaid and Medicare costs for the NF eligible and the non-NF eligible populations and to examine whether further refinements or alternate approaches might be warranted. Massachusetts, for example, used its linked data to propose alternate adjustment factors for Medicare payments to Senior Care Organizations. It found that the Medicare AAPCC methodology would underpay HMOs for frail seniors residing in the community and that even with a PACE adjustor, the Medicare payments for the community Nursing Home Certifiable population would be understated.

In Maine, where there are currently no HMOs doing business, a Medicare PCCM option is being developed. This will provide physicians with a case management fee for authorizing and coordinating Medicare services.

What kind of age, sex, or risk adjustments should there be?

Another question that must be addressed in the development of rate cells is whether to adjust for age, sex, region, eligibility status (people over 65 versus those with disabilities) or other risk factors. Most states include some kind of adjustments for age, sex, region and eligibility status but the use of risk adjustment methodologies is still in the early research and testing phase. Table 8 summarizes the adjustments that are currently used in the states that are being discussed in this paper.

Table 8. Approach to Age, Sex or Other Risk Adjustments in Selected Programs

	Medicaid Adjustments	Medicare Adjustments
Arizona Long Term Care System	No adjustments for age, sex, case mix. Elderly and physically disabled grouped together.	AAPCC with standard adjustments, when contractor is a Medicare HMO
Colorado Integrated Care and Financing	Medicaid financial eligibility	Adjustments for Mesa county; age, sex, institutional and welfare status, as appropriate, plus other risk adjustments (see previous table)
MaineNET	Adjustment for case mix of NFs and Residential care settings; other adjustments under review	N/A
Minnesota Senior Health Options	Adjustment for age, sex, county	AAPCC age, sex, county adjustments and PACE adjustor
Oregon Health Plan	Elderly and disabled are separate rate cells; with/without Medicare; for the elderly, adjustments for those with Medicare Part B only	AAPCC with standard adjustments, when contractor is Medicare HMO
PACE	Varies by state	no adjustments for age, sex, over 65 versus with disability, PACE Adjustor
Texas Star+Plus	No age, sex adjustments. Propose to adjust for enrollment differences of heavy users of medical and LTC.	AAPCC with standard adjustments

The use of adjustments for age, sex, region and disability group varies quite a bit from state to state. Whether to include such adjustments may be a function of the availability of data and the number of rate cells a state may want to administer. Particularly in programs where enrollment is voluntary and likely to involve low numbers, it may not make sense to include multiple rate cells for age, sex, and region.

On the other hand, voluntary programs with low potential enrollment are more prone to either favorable or adverse risk selection. Biased selection arises if the high risk type of enrollees within a rate cell tend to be found more in one plan or program versus another (e.g. in the fee-for service system or the managed care system). For example, if Medicare

HMO enrollees within each AAPCC cell tend to be lower risks, then Medicare payment rates, which are based on the average risk of FFS enrollees within each cell, would overstate the expected FFS expenditures of HMO enrollees.⁵

In Maine and Texas, it is proposed that the rates be adjusted, particularly during the start-up of the programs to reflect the actual enrollment distribution. In Texas, for example, the state will be monitoring the enrollment of those in the community rate cell to examine whether a disproportionate percent of people who have been heavy LTC users or have heavy medical/acute care needs are in enrolled in one plan or another. They propose to make adjustments either during the first year or at the end of the year to account for these differences. In Maine, the distribution of people who enroll in the NF-eligible rate cell will be monitored and adjusted to reflect major differences between the proposed and actual distribution of people in the community versus in a NF who are in the NF-eligible rate cell.

The use of risk-adjusted capitation rate structures for dually eligible individuals is extremely challenging yet important given the significant variation in costs between enrollees particularly among those with chronic conditions. A small number of people can account for a large proportion of health care expenditures and at the other extreme a large number of people can account for a very small percentage of expenditures. Depending on the enrollment distribution into plans, there is great potential for either excessive profits or losses.⁶ Research from the Medicare HMOs has demonstrated that Medicare HMO enrollees were less costly than non-HMO enrollees and that disenrollees had systematically higher costs than Medicare beneficiaries in the fee-for-service sector.⁷

Some of the factors that contribute to adverse risk selection can be mitigated by state policies such as third party management of enrollment, oversight of marketing, monitoring of disenrollment and requirements for network composition. Many states, for example, use health benefit administrators to manage enrollment. This prevents plans from selectively choosing who to enroll. Similarly, oversight of marketing materials and strategies can assure that plans are providing a consistent and accurate message to potential enrollees. Nevertheless, the potential for selection bias is still a potential problem for programs serving those with chronic conditions.

A number of research and demonstration efforts are in progress to develop more refined risk adjustment methodologies for Medicaid and Medicare managed care programs. With respect to Medicaid capitation methods, a Disability Payment System (DPS) has been

⁵Bryan Dowd, Ph.D. et al., "An Analysis of Selectivity Bias in the Medicare AAPCC," *Health Care Financing Review*, Spring 1996.

⁶Richard Kronick, Ph.D. et al. , "Diagnostic Risk Adjustment for Medicaid: The Disability Payment System, " *Health Care Financing Review*, Spring 1996.

⁷ Randall Ellis, Ph.D et al., "Diagnosis-Based Risk Adjustment for Medicare Capitation Payments," *Health Care Financing Review*, Spring 1996.

developed for Medicaid recipients with disabilities.⁸ The DPS consists of groups of diagnoses that have been associated with elevated future costs. The system relies on claims based diagnoses to predict expenditures in a subsequent year. A number of states are considering the use of this system for their Medicaid populations with disability. This system does require the use of claims based diagnoses and conditions and is potentially subject to gaming and inaccuracies related to the diagnostic codings. Nevertheless, it represents a next wave of risk adjustment methodologies that are being tested and considered for Medicaid recipients with disabilities.

Risk adjustments for the AAPCC are also being tested.^{9, 10} Research has been undertaken to develop risk adjustments that might be used as part of the second phase of the S/HMO demonstration. This model uses information collected from the Medicare beneficiary survey to predict health care costs. The research suggests that direct health status measures (diagnosis, perceived health and functional health status) and indirect health status measures (demographic characteristics) are predictors of resource utilization.

The biggest issue that needs to be addressed, from a state perspective, is whether it is possible to collect on a timely basis all the data that would be necessary to administer such a system. Furthermore, the use of self reported data has potential for gaming by the health plans although similar issues have been addressed in other payment systems that rely on reported health data (e.g. DRGs and case mix systems) through stepped up quality assurance programs. The use of health status measures as risk adjusters does have the advantage of reducing the selection and adverse risk bias otherwise inherent in the more global rate setting approaches. An interim step for states might be to collect much of this data as part of the enrollment process and use it to monitor adverse risk selection and plan performance over time.

Other risk adjustment capitation models are also being tested including the use of Ambulatory Care Groups (ACGs) and the Payment for Amounts for Capitated Systems (PACs) and the use of Diagnostic Cost Groups. Other research is focusing on the use of risk adjustments for the non-elderly.^{11 12} These models focus on Medicare payments and

⁸ Richard Kronick, Ph.D, et al., "Diagnostic Risk Adjustment for Medicaid: The Disability Payment System," *Health Care Financing Review*, Spring 1996.

⁹ Leonard Gruenberg, Ph.D., et al. , "Improving the AAPCC with Health-Status Measures From the MCBS," *Health Care Financing Review*, Spring 1996.

¹⁰ *Evaluating Alternative Risk Adjustors for Medicare*, Draft Report, March 1997, Center for Economics Research, Gregory Pope, Principal Investigator .

¹¹ Arlene Ash, Ronald Ellis et al., *Risk Adjustment for the Non-Elderly, Interim Report*, Health Economics Research, HCFA Contract 18-C-90462/1-02, May 1997.

¹² Allen Dobson, Jonathan Wiener et al., *The Development of a Diagnosis-Based Risk Adjustment System for Setting Capitation Rates for Under-65 Populations*, The Lewin Group, HCFA Contract 500-92-0021, April 1997.

alternatives that might be tested as adjustments to the AAPCC. These models are still in the research and development phase.

What kinds of risk sharing (e.g. risk corridors, re-insurance) should there be?

Often during the start-up phase of a program, the state and the program contractor are interested in ways to share in the risk of managing care for people with chronic conditions. Some of the ways in which this risk is shared is through the use of re-insurance provisions or through the use of risk corridors. In Minnesota and Arizona, re-insurance provisions have been developed. In Arizona, the state buys reinsurance that covers approximately 75-85% of the cost of care for individual cases that exceed certain thresholds. For example, the re-insurance will cover 75% of the costs of care in excess of \$12,000 for an individual with Medicare Part A coverage in an urban area. Similar thresholds are developed for those in rural areas and those without Medicare coverage. For catastrophic cases such as transplants or those with hemophilia, the reinsurance covers either 85% of the program contractors costs or in certain instances a pre-established amount for a specified condition.

In Oregon, the health plans are responsible for obtaining their own re-insurance and are often able to do so at rates that are lower than what the state would be able to obtain.

Another approach to risk sharing is the use of risk corridors. In the PACE program, risk corridors were used in the first three start-up years of the program to develop and refine their service delivery system before assuming full financial risk. If a program's revenues exceeded its expenditures, a risk reserve was created that was used to fund losses in subsequent years or to facilitate the program's assumption of full risk at the end of the start-up period. If the program's expenditures exceeded its revenues, the losses were shared by the program and its payors. Risk corridors were established such that the PACE programs were responsible for 100% of the losses within the first tier of a risk corridor. In the second and third tiers of the risk corridor (e.g. when expenditures exceeded revenues by 5% and 10%), the proportion of losses covered by the payors increased to 90% and 95% respectively. A payor's maximum loss was also specified depending on how many years the PACE program had been operating.

Of particular interest with the risk sharing mechanisms under the PACE programs is that the Medicaid and Medicare losses were shared proportionally. Thus while the PACE sites received two capitation rates: one from Medicaid and one from Medicare, the risk was shared by the two programs. Theoretically, at least, the pooling of the risk by the two programs provides the kinds of incentives that policy makers have been striving for, i.e. incentives to reduce programmatic cost shifting and to develop health prevention and promotion practices that will benefit both programs in the long run. In pending legislation before Congress that would make the PACE program permanent, the use of risk sharing would be eliminated.

Massachusetts is also proposing a modified version of the risk sharing model used for the PACE demonstration. Under this modified PACE model, the state would phase in

increasing risk for Senior Care Organizations over time using a series of risk corridors, defined as the difference between capitation payments and its actual spending. Unlike PACE, where only losses are shared by Medicaid, Medicaid would share in both up-side (savings) and down-side (losses).

In Texas, the Star+Plus program will share in the profits but not the losses with the plans. The first 3% of profits will be kept by the HMOs. Any profits between 3% and 5% will be split between the state and the HMOs and any profits over 5%, the state will keep.

Are the rates designed using an approach that will be budget neutral?

When states submit their Section 1115 Waiver applications, they must include a section on budget neutrality. It is important to have the framework for a capitation rate structure developed as part of the Waiver submission although the final capitation rates and final methodology will likely not be included in the Waiver document. Nevertheless, the Waiver should include the assumptions that will be embedded in the capitation rates that will produce savings over the course of the demonstration. The presentation of the cost neutrality projections will be at a more aggregate level than the final capitation rates.

The steps that must be included in the calculation of budget neutrality include: selecting a method for calculating the expenditure limit, selecting a base year, developing trend factors and identifying beneficiaries and services included in the expenditure limit. The following is a brief overview of these steps.¹³

HCFA requires that demonstrations conducted under Section 1115 Waiver authority be budget neutral, that is that the state may not receive more federal Title XIX matching funds under its demonstration than it would have received without it. To ensure budget neutrality, HCFA places a limit on the amount of Federal Financial Participation that the state can receive during the demonstration. This expenditure limit is based on a projection of how much the state would have received had there been no demonstration. A demonstration must be budget neutral over the entire demonstration period, not on a yearly basis.

To ensure budget neutrality, states must choose one of two methods for calculating the expenditure limit --- the per capita method or the aggregate method. The per capita method allows the benefits component of the expenditure limit to vary depending on actual enrollment during the demonstration. HCFA and the state negotiate a projected cost per enrollee which becomes the basis for a cap on the amount of federal financial participation the state will receive per enrollee. The per capita cost projections for budget neutrality should not be confused with the capitation rates the state plans to pay the health plans. For example, the per capita cost projection may include services that are not included in the capitation rates.

¹³HCFA Document, *Budget Neutrality of Comprehensive section 1115 Waiver Demonstrations*, December 1996.

Using the aggregate method, the expenditure limit does not vary with actual enrollment although separate enrollment and per capita costs projections may be made as intermediate steps in determining an aggregate limit. The expenditure limit is a fixed amount. A risk corridor under which HCFA could grant the state additional spending authority if caseload deviates from projected caseload can be established.

In calculating budget neutrality, a base year must be selected. This is usually the most recent year for which actual Medicaid data is available. Trend factors or growth rates are then applied to the base year data to project future expenditures with and without the demonstration program. HCFA requires the state to submit historical caseload and expenditure data in a standard format to determine historical program growth. Trend factors are negotiated between HCFA and the state.

Expenditures for those eligibility categories and services that the state proposed to include in the demonstration are included in the expenditure limit. Beneficiary eligibility categories and services for which it will be difficult to “carve-out” are also included in the expenditure limit, for example, services or beneficiaries included in the demonstration only in later years of the demonstration period.

What mechanisms can be used to promote the integration of Medicaid and Medicare financing and minimize programmatic cost shifting?

The development of Medicaid and Medicare capitation rate structures and financing systems is an intricate and subtle dance between state and federal policy makers. Each program is concerned about eliminating service fragmentation, containing costs and coordinating and improving quality care. Aligning the incentives of the two programs to meet those common goals is a challenging endeavor. If the incentives of the two programs are not more closely coordinated, the potential for significant cost shifting is great. At the same time, protocols and procedures implemented as part of the Medicaid program can result in significant savings for the Medicare program and vice versa.

Under the current system, the Medicaid program has limited ability to initiate care management programs or medical treatments that could prevent the onset of serious acute and chronic conditions. An example is pneumonia vaccines. It is clear that Pneumovax is extremely desirable and cost effective. However strongly Medicaid encourages this policy, it cannot track dually eligible clients who received the pneumovax when Medicare was billed and it cannot require the use of a service that is Medicare funded. Furthermore, the Medicaid program can have almost no impact on the majority of the Medicare population who should have received the vaccine at some point before also becoming Medicaid eligible. This is just one example of how the lack of integration between Medicaid and Medicare impedes the use of a simple yet highly effective preventive service that in the long run will save many lives, avoid hospitalizations and prevent the use of long term care services.

While much of the focus on the development of integrated managed care systems focuses on the organizational and financial dynamics between the two programs, it may be that

more work could be done to develop joint clinical protocols that would improve the health and well-being the dually eligible and that would in the long run save both programs money.

D. Integration Approaches and Waivers

As the seven programs featured in this paper illustrate, multiple vehicles exist to integrate Medicaid and Medicare, and each has its particular strengths, weaknesses and waiver requirements. In this section, we review three general approaches to dually eligible beneficiaries and the particular vehicles that have emerged under each approach. We then review the various waivers that have been used to construct dual eligibility programs from these vehicles.

D-1. Approaches to Integration

The following approaches should not be viewed as models. They are means to achieving program goals and, with several Medicare and Medicaid policy changes pending in the federal Balanced Budget Act of 1997, new approaches are likely to emerge. The arrangements listed here are not mutually exclusive. States may decide to use a variety of vehicles as, for example, Minnesota has done by contracting with both Medicaid plans and Medicare HMOs. States should carefully consider all of their options and select the one or more approaches that best fit their target populations, existing delivery systems, scope of services, public and private infrastructure and timelines.

Approach 1: Capitated Medicare and Medicaid through an Existing Medicare Vehicle

The number and variety of MCOs with existing Medicare risk contracts with HCFA has been increasing and options will expand further with enactment of the federal Balanced Budget Act of 1997. Under this approach, a state contracts for Medicaid services with an entity that already receives capitated Medicare payments from HCFA. Vehicles fall into two categories: those with standard Medicare risk contracts, and those who participate in national demonstration programs.

1-A. Beneficiary enrolls in an MCO with standard Medicare risk contract and a Medicaid contract.

This arrangement can be found in Arizona, Colorado, Florida, Minnesota and Oregon and is planned in Texas. Beneficiaries receive all Medicaid and Medicare services from a single organization, which until now has been a Medicare HMO. Under provisions of the federal Balanced Budget Act of 1997, provider sponsored organizations (PSOs), preferred provider organizations (PPOs) and others will also become eligible for Medicare risk contracts.

Using an existing Medicare risk contractor, a state may pursue Medicaid waivers to capitate Medicaid services to the Medicare MCO without pursuing Medicare waivers, since the MCO already receives a Medicare capitation from HCFA. This strategy is well suited to areas where there are sufficient Medicare HMOs to offer dually eligible beneficiaries a choice of plans. To date, Medicare risk contractors have been concentrated in the urban markets of a handful of states, where

Medicare payment rates are higher, but the federal Balanced Budget Act of 1997 will reduce the disparity between high and low payment areas over time, which may stimulate the Medicare risk market in less urban areas.

Since they are required to offer their plans to virtually all Medicare beneficiaries in their service areas, Medicare risk contractors may be attractive to states designing programs for broadly defined target groups. A state that defines its target group more broadly than beneficiaries who are nursing home eligible, for example, would not choose PACE, but might choose a Medicare risk contractor. Like PACE, a Medicare risk contractor with a Medicaid contract from the state gains considerable flexibility through dual capitation payments. Coordination with other programs such as state funded home care and Older Americans Act services is still necessary, although states may consider including state funded services in state capitation payments to serve beneficiaries who are at risk but are not nursing home certified.

Contacting with standard Medicare risk contractors offers opportunities for states yet there are some implications that must also be considered. Dually eligible beneficiaries will always have freedom of choice under any Medicare managed care arrangement. A dually eligible beneficiary may join an MCO for Medicaid services but remain in fee for service for Medicare services. If they use Medicare providers outside the network, care is more fragmented. In addition, Medicare risk contractors may not be interested in contracting with Medicaid or, if interested, they may not be willing to assume risk for long term care services. Medicare risk contractors may not exist everywhere in a state and, in fact, there were no Medicare HMOs in about ten states in June 1997 (though this problem is likely to diminish in some areas as more entities become eligible for risk contracts and geographic Medicare payment disparities are reduced). This does not pose a problem for states interested in developing integrated programs in selected areas, but it limits states that seeking to develop statewide programs. Medicare risk contractors also may not contract with traditional safety net providers or have experience in long term care.

States do have real opportunities to use this arrangement to integrate care for dually eligible beneficiaries while taking fuller advantage of Medicare benefits. Since most Medicare risk contractors offer supplemental benefits (e.g., prescription drugs) which duplicate Medicaid services, states may develop capitation payments that adjust for the added benefits already paid through the Medicare capitation.

As enrollment of Medicare beneficiaries in various Medicare risk plans rises, the potential for dually eligible beneficiaries to enroll in separate plans for Medicare and Medicaid increases. This is one phenomenon that states should actively avoid because beneficiaries will have two primary care physicians, different network providers and different benefit packages. Coordination is extremely difficult in these arrangements. Oregon avoids dual HMO enrollment by allowing members

who have enrolled in a Medicare HMO to remain in Medicaid fee for service if the selected Medicare HMO does not have a Medicaid contract with the Oregon Health Plan.

1-B. Beneficiary enrolls in an MCO with a Medicare demonstration contract and a Medicaid contract.

This option allows states to design programs using existing or planned HCFA demonstration programs. The demonstration programs include PACE, Social HMO II, EverCare and Medicare Choices, a program launched by HCFA in 1996 to expand enrollment in new managed care arrangements and to test a range of delivery system options that provide beneficiaries with broader choices and HCFA with more alternative payment arrangements.

Some states may be interested in the **Medicare Choices** demonstration because it tests the impact of contracting with plans that do not necessarily qualify fully under requirements for Medicare risk programs. The Choices program will measure the beneficiary interest in receiving Medicare services through Provider Sponsored Organizations (PSOs), Preferred Provider Organizations (PPOs), open-ended HMOs, point of service options, integrated delivery systems and primary care case management systems. The demonstration has also been designed to expand implementation options in such areas as risk adjustment, payment methods, certification requirements and quality monitoring systems. State Medicaid officials might consider approaching other demonstration sites to explore options for providing Medicaid capitation payments for dually eligible beneficiaries. Though an option for states to consider, the number of sites is limited and they are not available in all states. However, many of the entities targeted for the demonstration will become eligible for standard Medicare risk contracts under the federal Balanced Budget Act of 1997.

States are actively seeking to develop new **PACE** sites. Although limited by Congress to 15 sites, the federal Balanced Budget Act of 1997 will increase the number of available sites immediately and make the program permanent, expanding the availability of this program for states seeking to target nursing home certified, dually eligible beneficiaries in relatively small sites.

The number of **Social HMOs** is also limited and states have not been major partners in their development. While the Social HMO I model offered limited long term care benefits and capped the number of at risk enrollees, Social HMO II is more suited to serving dually eligible beneficiaries. In order to be selected as a Social HMO II site, projects had to demonstrate a capacity and approach to serving dually eligible beneficiaries. Between 40-50% of enrollees in programs approved for South Carolina and Contra Costa County California will be dually eligible.

The **EverCare** demonstration offers another, albeit limited, approach to target a

sub-population or to provide a base for further expansion. Sites participating in this demonstration manage Medicare acute care services for nursing home residents using geriatric nurse practitioners to authorize hospital admissions, and schedule clinic and physician visits. As currently designed, the program reduces Medicare spending by avoiding preventable hospital admissions. While the beneficiary benefits, Medicaid does not share the savings and expenditures could be higher. States could explore contracting with EverCare sites to manage Medicaid services and consider a payment methodology that reflects some of the savings realized by reducing Medicare hospital admissions. States could also enhance the scope and effectiveness of the program by including prescription drugs as part of the benefit to be managed by the site.

Approach 2: Capitated Medicare and Medicaid through a Medicaid MCO with Medicare Waivers

This approach differs from Approach 1 in that the state uses a Medicaid contractor as its base and adds Medicare, rather than beginning with Medicare contractors.

2-A. Beneficiary enrolls in traditional Medicaid MCO where capitated Medicare services are also available.

Under this approach, Medicaid would contract with MCOs that do not have standard Medicare risk contracts. A Medicare waiver is sought to allow the MCOs to receive Medicare capitation payments and to obtain the 30 day lock-in that is not otherwise available to plans without Medicare risk or demonstration contracts.

This approach allows states to build networks using providers with a history of and commitment to serving Medicaid beneficiaries. Typically, Medicaid-only networks do not fully qualify for Medicare contracts, accept under demonstration programs, yet they have more extensive experience serving low income populations and contracting with Medicaid. Despite this experience, Medicaid plans may be reluctant to accept risk for long term care services and they will have to build an adequate network. That is, institutional and community based long term care organizations would have to expand to include hospitals, physicians and other providers while physician/hospital based groups will need to develop a broader base of home and community care providers. Further, care management models familiar to programs serving very impaired beneficiaries will be new to organizations that have historically focused on primary and acute care.

2-B. Beneficiary enrolls in a community based organization that contracts with an MCO for health services.

States with extensive home and community based services programs which offer a single entry point for access to the long term care system might consider building on that experience. States would contract with and provide a Medicaid capitation payment to the single entry point or other community-based agency to

arrange or deliver care. The agency, since it is not likely to be a health care system, would subcontract with a licensed HMO or health care providers to deliver primary and acute care services. A Medicare waiver would be needed for the agency to receive capitated Medicare payments. This approach is being pursued by the Wisconsin Partnership program, and has many similarities to PACE sites.

This vehicle may be considered to build a system that values a social model of care and emphasizes consumer-centered or consumer-directed approaches to care. It is better suited to programs that serve beneficiaries already using long term care services. Beneficiaries who utilize only health care services probably would not be interested in enrolling in a system organized by an entity that does not deliver health care services. The strength of the approach is its focus on developing a plan of care on the individual needs of each beneficiary rather than authorization from a menu of services. Other models may adopt a similar style but this focus on flexible plans of care is more consistent with the philosophy of traditional community based organizations that have experience in home and community based long term care services.

Approach 3: Capitated Medicaid with Coordination of Fee-for-Service Medicare

The third approach involves contracts between Medicaid and MCOs for Medicaid services while Medicare services are delivered on a fee-for-service basis. This arrangement broadens the range of contractors available to Medicaid. Dually eligible beneficiaries could be required to enroll in the program for Medicaid services, but dually eligible beneficiaries would retain the right to use any qualified Medicare provider, so consumer incentives, enrollment counseling and member orientation and education would all need to stress the importance of using network providers to maximize coordination of care.

There are two constraints facing MCOs in this model. Beneficiaries may use Medicare providers that are part of the MCO's network but the providers can bill Medicare fee for service. Providers may not follow MCO procedures for prior authorization, reporting and care coordination. Incentives to shift costs continue and the extent of actual coordination depends upon the philosophy and willingness of network providers to coordinate care. When beneficiaries do receive services from out-of-network providers, coordination depends on the cooperation of providers who are reimbursed fee for service by Medicare and have no affiliation with the MCO. If the provider has affiliations with other MCOs, but not the one selected by the beneficiaries for Medicaid services, additional complications may emerge that reflect local markets and HMO-provider relationships.

Table 9 summarizes and compares the arrangements discussed above.

Table 9. Comparison of Integration Arrangements

Arrangement	Examples	Advantages	Concerns
1. Medicare Risk Contractors with Medicaid Contracts:			
A. Standard Contractors (Medicare HMOs and Others*)	Arizona, Colorado, Florida, Oregon, Texas	Medicare capitation possible without Medicare waiver; builds on existing networks; may be cost effective for states.	Medicare contractors may not want to contract with Medicaid or incur risk for long term care.
B. Medicare Demonstration Programs	Medicare Choices Demo; PACE**, Social HMOs, EverCare	Choices Demo may provide more flexibility; PACE, S/HMO and EverCare have experience with LTC users.	Demonstration programs may not be available; target population may too narrow (e.g., nursing home eligible).
2. Medicaid MCOs with Capitated Medicare via Waiver			
A. Traditional MCOs	Minnesota (MSHO)	Allows broader choice of MCOs. Uses providers with experience serving Medicaid beneficiaries. Medicare capitation and 30 day lock-in possible.	Requires Medicare waiver.
B. Community based organization with HMO/health care subcontracts	Wisconsin Partnership	Builds on LTC/ social model experience of community based agencies.	Requires strong relationship with health care partners. Better suited to nursing home eligible population. Requires Medicare waiver.
3. Medicaid MCOs coordinating with FFS Medicare	Arizona, Oregon	Allows broader choice of MCOs. Uses providers with experience serving Medicaid beneficiaries.	Medicare remains fee for service, which may promote cost shifting; integration may not be possible.

*Under provisions in the federal Balanced Budget Act of 1997, PSOs, PPOs and other entities are expected to qualify as standard Medicare risk contractors.

**PACE is expected to become a permanent option under the federal Balanced Budget Act of 1997.

D-2. Waiver Options

Note: As this document was going to print, the Balanced Budget Act of 1997 was moving toward swift enactment in the Congress. The following waiver analysis is based on current law as of July, 1997, which is likely to change significantly with passage of the budget agreement. We have attempted to indicate where current law is likely to change.

Medicare Waivers

1. Section 222

This limited Medicare waiver authority focuses on tests of new reimbursement or payment methodologies. It can be used to craft capitated Medicare payments to entities not otherwise contracting with Medicare, or to change the payment methodology for entities, such as Medicare HMOs, that already receive capitated Medicare payments. Minnesota has used a section 222 waiver for both purposes: it contracts with some entities that do not otherwise have Medicare risk contracts, and it negotiated Medicare payments with HCFA that vary from the standard AAPCC methodology. Although the HMO contractor in Colorado Integrated Care and Financing Project is a Medicare contractor, a 222 waiver was needed because the program will test an alternative to the AAPCC payment methodology.

HCFA cannot waive Medicare beneficiaries' freedom to choose their Medicare providers. Beneficiaries voluntarily enrolling in a Medicare risk plan must utilize network providers for the month in which their enrollment is effective but they may disenroll at any time for future periods.

Section 222 waivers may be used in combination with Medicaid waivers to capitate financing from both programs to a single MCO to create the financial flexibility and incentive to authorize the most appropriate and cost effective mix of services.

Medicaid Waivers

1. No Waiver Needed: Prepaid Health Plans

To date, without a waiver, states have had limited authority to capitate some but not all Medicaid services. Hospital inpatient and outpatient care, lab and x-ray services may not be included in the capitation payment. Physician services, ancillary services and long term care services may be included. Waivers are not required if the program is voluntary and the contracting plans meet the composition requirement (25% non-Medicare/Medicaid). The federal Balanced Budget Act of 1997 would expand the possibilities for Medicaid managed care without waivers. States will apparently be able to craft fully capitated plans by filing amendments to their state Medicaid plans, but the circumstances under which a state plan amendment will be sufficient are not clear at this time.

2. Section 1915(b) Waivers: Freedom of Choice

Section 1915(b) waivers allow states to implement mandatory Medicaid managed care programs which waive three primary requirements: beneficiaries' right to select Medicaid providers, comparability of services, and statewideness (all services must be available throughout the entire state). States can develop programs in particular geographic areas that provide health benefits that differ from the regular Medicaid program. These waivers allow states to require enrollment in primary care case management or gatekeeper programs, health maintenance organizations or prepaid health plans.

Federal guidelines require that beneficiaries have a choice of at least two plans, which may include a primary care case management option. Programs may include a six month lock in and a six month guarantee of eligibility. Section 1915(b) waivers are issued for two years and the program must be cost effective in each year of the waiver, that is expenditures under the waiver may not exceed expenditures that would have been made in the absence of the waiver.

This waiver may be used to construct programs for dually eligible beneficiaries that are mandatory as to Medicaid benefits only. Dually eligible beneficiaries always retain the right to receive Medicare benefits on a fee-for-service basis. While the Balanced Budget Act of 1997 allows states to construct mandatory Medicaid managed care programs without waivers (as amendments to their state plans), dually eligible beneficiaries are specifically exempted from the new state plan option. Therefore, states will continue to require waivers for mandatory Medicaid managed care programs that include dually eligible beneficiaries.

3. Section 1915(c) Waivers: Home and Community Based Services.

These waivers are very familiar to states operating home care programs. They allow states to fund Medicaid services that allow beneficiaries an alternative to placement in a nursing facility. In addition to covering services which are not considered "medical" or are not covered by as a state plan service, states may waive comparability, statewideness, community income and resource rules and rules requiring coverage of all eligible applicants. The latter provisions allow states to limit the amount of funds that will be spent on services.

The waiver process has been streamlined and allows states to develop a capitation payment for home and community based services for nursing home eligible beneficiaries. It also allows states to use the special income level for beneficiaries whose income exceeds the traditional Medicaid eligibility level. It targets the most costly population and is particularly helpful for serving people whose income exceeds Medicaid levels but who are likely to enter a nursing home and spend down. The 1915(c) waivers allow states to retain the special income level, up to 300% of the federal SSI benefit and the spousal impoverishment provisions for eligible beneficiaries, options not available under 1915(b) waivers. At least one state, Texas, has applied for both 1915(b) and (c) waivers to combine the long term care flexibility of (c) with the mandatory Medicaid feature of (b).

4. Section 1115: Research and Demonstration Waivers

Section 1115 offers states the broadest authority to test new approaches. The section allows states to implement mandatory managed care programs and waive federal requirements for eligibility, services (non-Medicaid long term care services may be included), comparability (amount, duration and scope of benefits), plan composition, statewideness and uniformity, freedom of choice, retroactive eligibility, cost sharing arrangements, asset limitations, deeming of income, HMO enrollment composition; and other areas.

1115 waivers are approved for five years and the waiver must be cost effective over the five year period rather than in each year of the demonstration. The cost neutrality formula measures the impact of the demonstration on all eligible beneficiaries, participating and non-participating, in the demonstration area. HCFA is responsible for contracting for an independent evaluation.

Table 10 summarizes the circumstances under which states required waivers as of July, 1997.

Table 10. Features of Medicaid and Medicare Waivers as of July, 1997

	Medicaid 1915 (b)	Medicaid 1915 (c)	Medicaid 1115	Medicare 222
Eligibility rules	May NOT be waived.	MAY be waived.	MAY be waived.	May NOT be waived.
Benefit requirements	May NOT be reduced but plans may add services.	Services MAY be added.	MAY be waived.	May NOT be waived.
Freedom of choice	MAY be waived except for certain benefits (emergency services, family planning, FQHC services). Requires choice of at least two delivery systems; permits up to 6 month lock in for federal qualified HMOs (state qualified, one month).	May NOT be waived.	MAY be waived; permits limitation of choice to once delivery system; permits extended lock in.	May NOT be waived (but plans may receive 30 day lock in).
Federal standards for full risk managed care plans	May NOT be waived.	May NOT be waived.	MAY be waived	NA
Provider reimbursement rules	MAY be waived in limited circumstances.	May NOT be waived.	MAY be waived.	MAY be waived.
State administration requirements (eligibility determination, quality control)	MAY be waived in limited circumstances.	May NOT be waived.	MAY be waived.	NA
Composition	May NOT be waived.	May NOT be waived.	MAY be waived	May be waived.

Selecting Waiver Options

States may use one or more waivers implementing programs for dually eligible beneficiaries. Programs that contract with existing Medicare risk or demonstration programs do not need waivers under section 222 to capitate Medicare payments, as long as they are willing to accept the standard AAPCC methodology. However, states may wish to broaden the pool of MCOs to include both Medicare risk contractors and other organizations that do not contract with HCFA under current programs. In some areas of the country, the Medicare payment methodology may not provide adequate funding for

program seeking to maintain very impaired beneficiaries in community settings. Section 222 waivers may be sought to propose a different payment methodology.

Partial capitation approaches, using the prepaid health plan option, may be used to establish or phase in a program. Wisconsin provided partial capitation payments to a large community based organization to initiate the Partnership Program, an approach originally developed for pre-PACE sites. This approach is easier to implement and takes less time than a more extensive waiver. It has helped Wisconsin start enrollment while a more comprehensive combination of 1115 and 222 waivers was being reviewed. While hospital, lab and x-ray services are billed fee for service, the Wisconsin has included incentives to manage fee for service utilization. Partnership plans are financially responsible for meeting performance targets for each service that is outside the capitation payment. The targets are based on historical fee for service expenditures. Utilization exceeding the targets can result in financial penalties.

1915 (c) waivers offer states an opportunity to add community based long term care services to MCOs with existing Medicare or Medicaid risk contracts. Florida is preparing to implement an integrated model using a 1915(c) waiver contracting with Medicare HMOs in selected counties. Participation in Florida will be voluntary.

To date, most states have used Section 1115 waivers to serve dually eligible beneficiaries. Though states request 1115 waivers for many reasons, the most common affecting dually eligible beneficiaries is a waiver of composition requirements, allowing states to contract with Medicaid plans that have little or no commercial enrollment.

Table 11. Medicare/Medicaid Arrangements and Waivers in Selected Programs

Program	Waivers	
	Medicaid	Medicare
Arizona Long Term Care System	1115	None
Colorado Integrated Care and Financing Project	1115	222
Florida	1915 (c)	None
MaineNet	1115 pending	Being considered
Minnesota Senior Health Options	1115	222
Oregon Health Plan	1115	None
PACE	1115	222
Texas Star+PLUS	1915 (b) and (c) pending	None

E. Conclusion

This is a time of change and opportunity for states wishing to integrate acute and long term care for dually eligible beneficiaries. The Robert Wood Johnson Foundation and the Health Care Financing Administration have both committed resources to improving care for dually eligible beneficiaries, and the early experience of existing demonstrations is beginning to provide valuable information for the next round of experiments.

Changes to Medicare and Medicaid in the federal Balanced Budget Act of 1997 are likely to expand the number of vehicles available to states as they contemplate integration projects. Provider sponsored organizations (PSOs), preferred provider organizations (PPOs) and others will qualify for Medicare risk contracts, Medicare's 50/50 composition rule will be replaced with enhanced quality standards, and Medicare payments based on the AAPCC will gradually make rural and other low payment areas more attractive to MCOs. In Medicaid, certain managed care plans that previously required waivers will not require them in the future, though any managed care program targeted to dually eligible beneficiaries will almost certainly continue to require waivers.

Changes in federal policy may open new options for dually eligible beneficiaries, but they will not make integration any easier to accomplish at the program level. States still need to break integration into its component parts and pay attention to each component, whether or not waivers are needed. Integration calls for nothing less than reinvention of care delivery, which will take strong leadership from both states and HCFA.

The array of new possibilities reinforces the importance of goal setting. Once a state has clear goals for its integrated program, it can choose from among a growing set of possible vehicles. Absent clear goals, choosing vehicles will become more confusing as the possibilities multiply.